

065172 SEP 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF THE TIME OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 200 W. HENRISON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 22424					
1. DECEASED NAME (PRINT) UNKNOWN 87-60 WF						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6-16-87				2b. HOUR M 3:30	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Unknown		6. AGE (IN YEARS) LAST BIRTHDAY YRS. Unknown		7. IF UNDER 1 YR. MONTHS DAYS Unknown		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-16-87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? Unknown		8. MARRIED WIDOWED NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Unknown		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES NO		13e. STREET ADDRESS Unknown		9999	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				16. ADDRESS Officer Peters - B.P.D. Southern District			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown				18. SOCIAL SECURITY NO. Unknown		19. INFORMANT ADDRESS Officer Peters - B.P.D. Southern District					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Methylphenidate and phencyclidine</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>intoxication</u> DUE TO, OR AS A CONSEQUENCE OF <u>unpending 6-29-87</u> (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH?				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 6-?-87 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) ingestion of drugs					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, STORE, ETC.) unknown		21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 6-16-87			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 9-3-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board Balto., Md.				25. DATE REC'D. BY REGISTRAR SEP 9 1987				25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

07/84
25M

BP

DHMH - 17
WR A15 ME (5))

002155 SEP 10 97

20% COTTON - 25K
DINOVA
25K



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The physician's signature and seal are required on pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22425

1. DECEASED NAME (TYPE OR PRINT)		FIRST Sidney		MIDDLE M.		LAST Abbott		20. DATE OF DEATH MONTH DAY YEAR 8-4-87		26. HOUR 3 ³⁰ A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-6-1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.						
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Printing				
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3004 Beverly Rd. 21214		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Meisel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Booker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Joan A. Gay, 5 Bideford Ct. 21234								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEVERE BRADYCARDIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A-V BLOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>SEE DR</u> DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>87</u> , to <u>8/4</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>S. Paulino</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. Paulino</u>				22e. ADDRESS <u>5601 Rock Haven Rd. Balto. Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-7-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.						
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.						25a. DATE REC'D. BY REGISTRAR AUG 5 1987		25b. REGISTRAR'S SIGNATURE <u>John R. Ruck</u>				

MEDICAL CERTIFICATION

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062091 AUG - 8 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 12 2 4 2 6

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DORIS D ABELL		2a. DATE OF DEATH MONTH DAY YEAR 08-03-87		2b. HOUR 9 P.M.	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 10-02-1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levin Dale Nsg Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING INDUSTRY) SALES		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE Md	13b. COUNTY BALTIMORE	13c. CITY/TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3514 LANGREHR RD. APT. 1B 21207	
14. FATHER'S NAME (TYPE OR PRINT) NATHAN ISRAEL SNYDER		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) LILLIAN PRUCE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-12-9103		17. INFORMANT DAVID ABELL APT. 1B 3514 LANGREHR RD. BALTO., MD 21207	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cu lung with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/87
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>87</u> , to <u>8/13</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/4/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. M. W. W. M.		22e. ADDRESS Levin Dale Grate Rd 21207	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE AUG. 5, 1987	23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME Sol Levinson & Bros		ADDRESS 6010 Rristre Town Rd	25a. DATE REC'D. BY REGISTRAR AUG 5 1987

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100-100000-100000

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22427

REG. NO.

1- FOR
STATE
REGISTRARDECEASED NAME FIRST MIDDLE LAST
Howard W. Adams Sr.
2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
August 15 1987 2:40AM3 SEX Male 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR
February 3, 1915 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS
IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD

10 CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Metallurgical Supr. 12b KIND OF BUSINESS OR INDUSTRY Beth. Steel

13a STATE Maryland 13b COUNTY Baltimore 13c CITY OR TOWN Dundalk 13d INSIDE CITY LIMITS? YES ☐ NO ☒ 13e STREET ADDRESS / ZIP CODE 504 Bayside Drive 21222

14 FATHER'S NAME FIRST MIDDLE LAST Howard Lot Adams 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Palmer

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b SOCIAL SECURITY NO. 213-09-1391 17 INFORMANT ADDRESS Sarah J. Adams 504 Bayside Drive 21222

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma Of Prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two YearsDUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☐ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from July 27, 1987, to August 15, 1987, that (we) last saw the deceased alive on August 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.

22b SIGNATURE U. UGUR DEGREE 22c DATE SIGNED
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d PHYSICIAN'S NAME (TYPE OR PRINT) A. UGUR CAM 21 22e ADDRESS C/O Maryland General Hospital

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 8-18-87 23c NAME OF CEMETERY OR CREMATORY Meadowridge 23d LOCATION CITY OR TOWN COUNTY STATE Dorsey Maryland

24 FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk ADDRESS 7922 Wise Ave. Dundalk, MD 21222 25a DATE REC'D. BY REGISTRAR AUG 18 1987 25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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AUG 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22428

1. DECEASED NAME (TYPE OR PRINT) JACK			2a. DATE OF DEATH MONTH DAY YEAR Tues. 8-25-87			2b. HOUR MIN. 8:30 A			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1-30-57		6. AGE (IN YEARS LAST BIRTHDAY) 67		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 622 N. MONROE ST. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST JACK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE FEATHERSTONE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 250 14 4567		17. INFORMANT MRS. EVERLENA ADAMS		ADDRESS 622 N. MONROE ST.		ZIP CODE 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dialysis dementia DUE TO, OR AS A CONSEQUENCE OF (b) End stage Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ASCVD									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/25/87 to 8/25/87 , that (I) (we) last saw the deceased alive on 8/25/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. BELTRAN				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. BELTRAN				22e. ADDRESS 1940 W. BALTIMORE ST. BALTO					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/2/87		23c. NAME OF CEMETERY OR CREMATORY MD. NAT. MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL (PRINCE GEO.) MD.			
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN				ADDRESS 4517 PARK HEIGHTS AVE. 21215		25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. LINDSEY CITY

2. SOUTH CAROLINA

3. ST. LOUIS

4. INDIANAPOLIS

5. NEW YORK

6. BOSTON

7. ST. PETERSBURG

8. LOS ANGELES

9. X

10. WASHINGTON

11. PHOENIX

12. MEMPHIS

13. ALBUQUERQUE

14. DENVER

15. JACKSON

16. ST. LOUIS

17. ST. LOUIS

18. ST. LOUIS

X

19. ST. LOUIS

20. ST. LOUIS

064226 AUG 31 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22429
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAGGIE D ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 8 / 26 / 87		2b. HOUR 8:10 PM	
3. SEX F	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 4 / 13 / 23		6. AGE (IN YEARS LAST BIRTHDAY) 64		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Weldon, N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Balto		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Wallace		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Wallace Harris		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 239-32-3835		17. INFORMANT ADDRESS Melvin Adams 2940 Arunah Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CANDIDA / STAPH SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE SKIN REACTION & MUCOSITIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 1 WK 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0 RENAL FAILURE / POSSIBLE BRAIN METASTASES.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 / 19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (he, she, it) attended the deceased from 8/19 to 8/26 , 19 87 , that (he, she, it) lost consciousness on 8/26 , 19 87 , and that in (my, your) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)						
22b. SIGNATURE Varma, MD		DEGREE		22c. DATE SIGNED 8/26/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VARMA		22e. ADDRESS UNIV. HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-29-87		23c. NAME OF CEMETERY OR CREMATORY King Mem Park		
23d. LOCATION CITY OR TOWN Balto		COUNTY Md		STATE		
24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons		ADDRESS 1701 Laurens		25. DATE REG'D. BY REGISTRAR AUG 28 1987		
25. REGISTRAR'S SIGNATURE J. L. Davidson-Randall						

MEDICAL CERTIFICATION

1
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

062974 AUG 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22430

1. DECEASED NAME (TYPE OR PRINT)			FIRST MAY			MIDDLE R.			LAST ADAMS			26. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR			26. HOUR 8 13 19 87		
3. SEX F		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 5 7 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		27. DATE PRONOUNCED DEAD			27. HOUR 8 13 19 87		
14. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				15. CITIZEN OF WHAT COUNTRY? U.S.A.				16. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				17. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				MD	
18. CITY OR TOWN OF DEATH Baltimore				19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2505 Overland Ave.								20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher				21. KIND OF BUSINESS OR INDUSTRY Balto. Public	
22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2505 OVERLAND AVE							
23. FATHER'S NAME FIRST MIDDLE LAST George Richards				24. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Forrest				25. INFORMANT Dr. Frederick K. Adams				ADDRESS					
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				27. SOCIAL SECURITY NO.				28. INFORMANT Dr. Frederick K. Adams				ADDRESS					
29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
30. DATE OF OPERATION				31. CONDITION FOR WHICH OPERATION WAS PERFORMED?								32. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
33. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
36. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				37. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				38. LOCATION STREET CITY OR TOWN COUNTY STATE									
39. I certify that, to the best of my knowledge, the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
40. ACTUAL SIGNATURE Charles P. Kokes				41. TITLE (SPECIFY) M.D. Assistant				42. MEDICAL EXAMINER				43. DATE SIGNED 8-14-87					
44. EXAMINER'S NAME (TYPE OR PRINT)				Charles P. Kokes, M.D.				45. ADDRESS 111 Penn St., Balto., MD				21201					
46. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				47. DATE 8/18/87				48. NAME OF CEMETERY OR CREMATORY Dulany Valley Cem.				49. LOCATION CITY OR TOWN COUNTY STATE 200 RADONIA Rd					
50. FUNERAL DIRECTOR NAME Locks Funeral Home				51. ADDRESS 1304 N. Central Ave				52. DATE REC'D. BY REGISTRAR AUG 17 1987				53. REGISTRAR'S SIGNATURE John Deaton-Randall					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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INDEXED MATERIAL

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FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 4 3 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOMER L. ADLEBERG			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10, 1987		2b. HOUR 6:18 PM								
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 9, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK, FORM, OR OF WORKING LIFE) BROKER		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE APT. 104 7121 PARK HTS. AVE. #21215					
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS ADLEBERG						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE COHEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WV-11-AIR FORCE 212-18-5368		17. INFORMANT MRS. SELMA ADLEBERG APT. 104 7121 PARK HTS. AVE. BALTO., MD 21215		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/13</u> , 19 <u>85</u> , to <u>4/27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Samuel Benesh</u> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 8/11/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL BENESH, M.D.						22e. ADDRESS 11 SLADE AVE. BALTO., MD 21208							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM. PARK			23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR AUG 14 1987						25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 2 4 3 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD AITKEN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 27, 1987		2b. HOUR 7:30p M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 11 05		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY none
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1701 Easton Blvd Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 22 8-10 6776		17. INFORMANT NAME ADDRESS Mary Home 1701 Easton Blvd Baltimore	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION PNEUMONIA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 23, 19 87 , to AUGUST 27, 19 87 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 27, 19 87 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chu-Huang Chen M.D.		DEGREE M.D.		22c. DATE SIGNED 8/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHU-HUANG CHEN		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		23b. DATE 9 1987	23c. NAME OF CEMETERY OR CREMATORY York Zipp		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME William L. McPherson		25a. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Kocher	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 22

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062407 AUG 1

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22433
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE AKONOM			2a. DATE OF DEATH MONTH AUGUST DAY 5 YEAR 1987		2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH JANUARY DAY 26 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	# UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2221 FLEET STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AM. CAN. CO.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS ZIP CODE 2221 FLEET STREET 21231	
14. FATHER'S NAME FIRST MIDDLE LAST Jankowski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHN STACHINSKI 523 S. KENWOOD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212 09 5031		17. INFORMANT JOHN STACHINSKI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) HYPERTENSIVE CVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/5 19 87 to 8/5 19 87 , that (I) (we) last saw the deceased alive on NOT SEEN 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Irvin B. Kaplan MD				22c. DATE SIGNED 8/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVIN B. KAPLAN, MD				22e. ADDRESS 129 S. BROADWAY 21231	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE AUG. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS	
23d. LOCATION (CITY OR TOWN) BALTIMORE		23e. COUNTY M.D.		23f. STATE	
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.		25. DATE REC'D. BY REGISTRAR AUG 7 1987	
26. REGISTRAR'S SIGNATURE Julia D. ...		27. REGISTRAR'S SIGNATURE ...			

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

065403 AUG 11 61

62304 AUG 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22434

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis C. Aleshire			2a. DATE OF DEATH MONTH DAY YEAR August 8 1987		2b. HOUR M M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 12, 1939		6. AGE (IN YEARS LAST BIRTHDAY) 47	IF UNDER 1 YEAR MONTHS DAYS YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3819 South Hanover Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Examiner	12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY =====	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3819 South Hanover St 21225	
14. FATHER'S NAME FIRST MIDDLE LAST =====		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolly Kline			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-36-1934	17. INFORMANT ADDRESS Valerie Aleshire Same as 13e			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Brain metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung Cancer</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>6 mo.</u> <u>6 mo.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>=====</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> 19 <u>87</u> to <u>7/30</u> 19 <u>87</u> , that (I) (we) last saw the deceased above <u>(I)</u> (we) (did not) saw the body after death 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <u>Wm C. Waterfield</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8-10-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm. C. Waterfield</u>		22e. ADDRESS <u>St Agnes Hospital</u> <u>900 Cath Ave Balto Md 21229</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md			25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for the burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

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AUG 10 1981

062003 AUG-8-87

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 4 3 5
REG. NO.

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Winifred Ardith ALIFF			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 2, 1987		2b. HOUR 3:10 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 10 14		6. AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Virginia			13b. COUNTY York	13c. CITY OR TOWN Tabb	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Eugene Roberts, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle May Ledbetter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 230-05-3957		17. INFORMANT ADDRESS Sandra Aliff Hawkins 4462 Rt. 134 23602	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>multiple myeloma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 10 d 3 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Resp. failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21/87</u> , 19 <u>87</u> , to <u>8/2</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Lewis</u>		DEGREE		22c. DATE SIGNED <u>8/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lewis		22e. ADDRESS 600 N. WOLFE ST. BALTO. MD. Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B		23b. DATE 8/6/87		23c. NAME OF CEMETERY OR CREMATORY parkman park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore York Va.		23e. NAME OF CEMETERY OR CREMATORY parkman park		23f. LOCATION CITY OR TOWN COUNTY STATE Baltimore York Va.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ		ADDRESS 2222 W York Ave		25. DATE REC'D. BY REGISTRAR AUG 5 1987	
25. REGISTRAR'S SIGNATURE A. L. Anderson-Randall					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

b 227 71 95

ALIFF, ARDITH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. The funeral director should also complete the death certificate, page 4, and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and enter.

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063169 AUG 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8 7 2 2 4 3 0	
FOR STATE REGISTRAR Clara G. Allen		1. DECEASED NAME (TYPE OR PRINT) Clara G. Allen	
2a. DATE OF DEATH 8 14 87	2b. HOUR 7:20 A.M.	3. SEX FEMALE	
4. RACE WHITE	5. DATE OF BIRTH 9 15 03	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home Maker	13a. STATE MD	
13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME John LAYER	15. MOTHER'S MAIDEN NAME Maude Julien	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 214-12-0639	17. INFORMANT Patricia C. Mandris	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Metastatic breast cancer</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 27</u> 19 <u>87</u> to <u>August 14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Thomas Sweet</u> MD.			22c. DATE SIGNED <u>Aug. 14, 1987</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas Sweet</u>			22e. ADDRESS <u>77 S. Greene St.</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/17/87	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION Baltimore A.A. MD
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR AUG 17 1987	25b. REGISTRAR'S SIGNATURE <u>Julia D. [Signature]</u>

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22437
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Deneia S. Allen			2a. DATE OF DEATH MONTH DAY YEAR 8 19 87			2b. HOUR 407 PM			
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 12 86		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 7 7		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of MD Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1002 Woodington Rd. Balto 21229	
14. FATHER'S NAME FIRST MIDDLE LAST MARVIN M. ALLEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TONYA MEDGETT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS TONYA MIDGETT 1002 N. WOODINGTON ROAD							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AIDS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Stephen J. Hittman</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hittman, Stephen J.		22e. ADDRESS University Hospital - Dept of Pediatrics			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/22/87		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ANN ARUNDEL CO. MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH		ADDRESS 1101 E. NORTH AVENUE 21202		25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified by page 4.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE KNOWN OF DEATH ☒ ESTI- MATED ☐ 8-2-87 19
2b. HOUR M

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH DAY YEAR
1 31 87

6. AGE (IN YEARS)

LAST BIRTHDAY)
MONTHS DAYS
7

IF UNDER 1 YR.

MONTHS DAYS
7

IF UNDER 24 HRS.

HOURS MIN
7

2c. DATE

PRONOUNCED DEAD
8-2-87 19

7. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

BALTO.

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1837 N. Collington Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

N/A

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1512 MADERIA STREET 21231

14. FATHER'S NAME

FIRST MIDDLE LAST
REGINALD

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
JACQUELINE

GLADDEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

ADDRESS

JACQUELINE GLADDEN 1504 N. COLLINGTON AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sudden infant death syndrome

DOE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Dennis F. Smyth, M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 8-2-87

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/6/87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

23d. LOCATION

Ann Arundel Co.

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

WM. C. March F/A

ADDRESS

1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR

AUG 05 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WAVERLY ALLEN		2a. DATE OF DEATH MONTH DAY YEAR 8/21/87		2b. HOUR 9:45 P.M.					
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		8. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIEDLER'S Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER					
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. STREET ADDRESS BALTO, MARYLAND 2449 SHIRLEY AVE. 21215					
14. FATHER'S NAME FIRST MIDDLE LAST CORNELIUS ALLEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIANNA BROWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
17. SOCIAL SECURITY NO. 216 09 5617		18. INFORMANT MRS. BALTIMORE, MARYLAND 21217 LUCY ALLEN 2239 REISTERSTOWN, RD.		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 9 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Sepsis pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (was hospital) attended the deceased from Jan 28, 1985, to Aug 2, 1987, that (I) (was) last saw the deceased alive on Aug 2, 1987, and that in (my) (best) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE MANUEL LEVIN MD		22c. DATE SIGNED 8/27/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN MD					
22e. ADDRESS 601 PARK HILLS AVE BALTO MD 21215		22f. DATE REC'D. BY REGISTRAR AUG 10 1987		22g. REGISTRAR'S SIGNATURE Julia Bender-Rudman					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8/7/1987		23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS CEMETARY INC.					
23d. LOCATION CITY OR TOWN BALTIMORE, MD.		23e. COUNTY BALTIMORE, MD.		23f. STATE BALTIMORE, MD.					
24. FUNERAL HOME NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTIMORE, MD. 21216		25. DATE REC'D. BY REGISTRAR AUG 10 1987		25. REGISTRAR'S SIGNATURE Julia Bender-Rudman					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Anne</u> <u>RUTH</u> <u>Allison</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>August 9, 1987</u>					2b. HOUR <u>12:40pm</u>	
3. SEX <u>F</u>		4. RACE <u>B</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>6/23/31</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>56</u>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <u>YRS.</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>SPARTONBURG, S.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Maryland General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Church Home Hosp. Nursing</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <u>MD.</u>		13b. COUNTY <u>BALTO.</u>		13c. CITY OR TOWN <u>BALTO.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>2236 Linden Ave. 21217</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>HICKS PILGRIM</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>NELLIE CHEEKS</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>N/A</u>		17. INFORMANT <u>CLARENCE ALLISON</u>		ADDRESS <u>2236 LINDEN AVE.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 29, 1987</u> to <u>August 9, 1987</u> that (X) (we) lost saw the deceased alive on <u>August 9, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>						22e. ADDRESS <u>Maryland General Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>8/14/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EASTVIEW CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO., MD.</u>				
24. FUNERAL DIRECTOR NAME <u>[Signature]</u>						25a. DATE RECORDED BY REGISTRAR <u>AUG 11 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 4 4 1
REG. NO.

1. FOR
STATE
REGISTRAR

063847

2. DECEASED NAME FIRST MIDDLE LAST ADA D. ANDERSON		3. DATE OF DEATH MONTH DAY YEAR AUGUST 18, 1987		4. HOUR 12:27 M	
5. SEX Female	6. RACE White	7. DATE OF BIRTH MONTH DAY YEAR April 10 1914		8. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland 15b. COUNTY Harford 15c. CITY OR TOWN Havre de Grace		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS / ZIP CODE 301 Commerce St. 21078	
18. FATHER'S NAME FIRST MIDDLE LAST Newton W. Anderson		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella M. Blackson		20. ADDRESS North East, Maryland 21901	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		22. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-5102		23. INFORMANT Roger Reynolds	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ACUTE RENAL FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>42 minutes</u> <u>72 hours</u> <u>4 days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)	
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE	
34. I certify that (1) (this hospital) attended the deceased from <u>August 13, 1987</u> to <u>August 18, 1987</u> , that (1) (last) saw the deceased alive on <u>August 18, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
35. SIGNATURE <u>Eric Brown</u>		36. DEGREE MD		37. DATE SIGNED 8/18/87	
38. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Brown MD		39. ADDRESS Johns Hopkins Hospital 21205			
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE Aug. 20, 1987		42. NAME OF CEMETERY OR CREMATORY Principio Cemetery	
43. LOCATION CITY OR TOWN COUNTY STATE Perryville Cecil Maryland		44. DATE REC'D. BY REGISTRAR AUG 25 1987			
45. REGISTRAR'S SIGNATURE Lee A. Patterson & Son, Perryville, Maryland		46. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The lot required for the death certificate must be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then page 4 should be attached to the permit. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. 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063719 AUG 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22442
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARION V. ANDREASIK			2a. DATE OF DEATH MONTH DAY YEAR 8 19 87			2b. HOUR 1125PM					
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 604 S. Curley Street 21224		
14. FATHER'S NAME FIRST MIDDLE LAST James Andreasik			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Slimkowska			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-07-9547	
17. INFORMANT ADDRESS Theresa R. Andreasik 604 S. Curley St. 21224											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION ACUTE DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a PULMONARY + GASTROINTESTINAL HEMORRHAGE / CHRONIC I.T.P.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael E. Pelczar			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/21/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. PELCZAR MD			22e. ADDRESS ST. AGNES HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug 22 1987		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 24 1987					
						25b. REGISTRAR'S SIGNATURE John Anderson-Ruck					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, these pages, carbon papers, pages 1 and 2, should be filed with 107 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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064300 AUG 3 1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 4 4 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLENN ELSWORTH ANDREW			2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1987		2b. HOUR 11:15PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07/07/1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 1 37	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN CORDOVA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE RT. 1 BOX 140 21625		14. FATHER'S NAME FIRST MIDDLE LAST HOWARD ANDREW		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLENDA BUTLER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT GLENDIA ANDREW		ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>MULT. CONGENITAL ANOMALIES</u> at birth							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>RENAL AGENESIS, HYPOPLASTIC LUNGS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> 19 <u>87</u> , to <u>7/7</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/7/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>L M Smith Resor, MD</u>				DEGREE MD		22c. DATE SIGNED 7/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L M SMITH RESOR, MD				22e. ADDRESS JHH, DEPT OF PEDS		600 N. WOLFE ST.	
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 7/8/87		23c. NAME OF CEMETERY OR CREMATORY JHH		23d. LOCATION CITY OR TOWN COUNTY STATE 600 N. WOLFE ST. BALTO., MD. 2120	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D BY REGISTER		25b. REGISTERED	

MEDICAL CERTIFICATION

19

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the funeral director should be described for use on the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)



063212 AUG 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 4 4

1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH				MONTH DAY YEAR				2b. HOUR	
JENNIE ANDREWS								8-15-87								M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
M		B		1 1 14		73 YRS.						8-15-87				11:08	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
MD				U.S.A.								Baltimore City				MD	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				225 N. Fulton Avenue				RETIRED				N/A					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD						BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		225 N. FULTON AVE. 21223							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
JAMES THOMAS				FRANCES													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
NO				218-12-3075				GERALD DeSHIELDS 6616 AQUARIUS CT.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY?																	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
TITLE (SPECIFY)																	
M.D. Assistant MEDICAL EXAMINER																	
DATE SIGNED 8-16-87																	
ACTUAL SIGNATURE <u>Mario F. Golle, Jr.</u>																	
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY		STATE	
BURIAL				8/20/87		MOUNT ZION CEMETERY				BALTIMORE,						MD	
24. FUNERAL DIRECTOR																	
NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.																	
25a. DATE REC'D BY REGISTRAR 8-18-87																	
25b. REGISTRAR'S SIGNATURE																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25M

BP

DHMH - 17
(VR A15-ME (5))

003515 WAG 30 61

20% COTTON BLENDED

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WIND
WIND



064774 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the vital director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon patient page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiners must be called and advice obtained.)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 22445

1. DECEASED NAME (TYPE OR PRINT) SARA ELIZABETH (BETTY) ANDREWS		2a. DATE OF DEATH MONTH DAY YEAR August 26, 1987		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 5, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3939 Roland Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Producer	12b. KIND OF BUSINESS OR INDUSTRY Television
13a. STATE Maryland		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Saffold White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fay Twitty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-40-0439	17. INFORMANT ADDRESS 21111 John H.P. Andrews 1205 Corbett Road Monkton		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>84</u> , to _____, 19 _____, that (I) (we) lost saw the deceased alive on <u>8/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Alan Kimmel</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/26/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Kimmel		22e. ADDRESS 220 West Coldspring Lane		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-31-87	23c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Greenville Merriwether Georgia	
24. FUNERAL DIRECTOR (NAME) Mitchell-Wiedefeld Home 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR SEP 3 1987		
		25b. REGISTRAR'S SIGNATURE <u>India Davidson-Rudess</u>		

BP _____

064774 SEP-40

COTTON FIELD

100 8932

10
061833 AUG -5 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22440

1. DECEASED NAME (TYPE OR PRINT) BAGLEY V. ANGELA		2a. DATE OF DEATH MONTH DAY YEAR 08 01 87		2b. HOUR 10:5 AM
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 22 29	6. AGE (IN YEARS LAST BIRTHDAY) 58	IF UNDER 1 YEAR MONTHS DAYS 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Club social Dir.		
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank Dorazio		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alvina Dorazio		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 082-24-2423	17. INFORMANT ADDRESS Michael J. Herberger P.O. Box 65 Churchville, Md. 21028	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe pulmonary hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Silicosis - CREST syndrome				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 7/11/87 , 19 87 , to 8/1 , 19 87 , that (I) (we) saw the deceased alive on 8/1 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Elias Ghandour		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/1/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELIAS GHANDOUR		22e. ADDRESS 5601 LOCH RAVEN BLVD BALTO MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 4, 1987	23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md.	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, 333		ADDRESS S. Parke St. Aberdeen, Md. 21001	25. DATE REC'D. BY REGISTRAR AUG 4 1987	26. REGISTRAR'S SIGNATURE <i>Julia...</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. This certificate must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and diagrams on lined paper, including a large 'X' and various illegible text.

061737 AUG -587

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22447

REG. NO. 14

2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
August		1 1987		8:20PM	
3 SEX		4 RACE		5. DATE OF BIRTH	
Female		White		MONTH DAY YEAR May 6 1903	
6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
84		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		4214 Doris Avenue		Housewife	
12b KIND OF BUSINESS OR INDUSTRY		13a STATE		13b COUNTY	
Home Maker		Maryland		Baltimore	
13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4214 Doris Avenue 21225	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Michael		Catherine		No	
16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
220-01-3708		William J. Beran		21225 Ballman Ave Balto Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>anway obstruction</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of oral cavity</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>May 1987</u> to <u>August 1987</u> , that (1) (we) last saw the deceased alive on <u>July 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Edward S. Gonce</u>		MD		5/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Edward S. Gonce		7731 Ritchie Hwy		21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		8/3/87		Westview Mem Park	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Catonsville		Balto		Md	
24 FUNERAL DIRECTOR		24a. ADDRESS		24b. DATE REC'D. BY REGISTRAR	
George J. Gonce		4001 Ritchie Hwy Balto Md		AUG 04 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Page 2) and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, interested parties must be notified by mail.

061537 AUG-281



CHILLYN

100% COTTON FIBER

64867 SEP-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22448
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glennis T Armstrong			2a. DATE OF DEATH MONTH DAY YEAR 8 30 87		2b. HOUR 5:27 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 15 20	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Securus Hospital 2000 W. Balt St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disable	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY Baltimore City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Julian L. Tyree		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Perkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-44-6011	17. INFORMANT ADDRESS Mrs. Melva D. Gohlestown 4024 1/2 Garrison Blvd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal failure DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart failure & Pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/30 1987 to 8/30 1987, that (I) (we) last saw the deceased alive on 8/30 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. BELTRAN MD				22c. DATE SIGNED 8/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. BELTRAN				22e. ADDRESS 1940 W. BALTIMORE ST	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/4/87	23c. NAME OF CEMETERY OR CREMATORY Westview M. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD		
24. FUNERAL DIRECTOR NAME Chatman Harris FH 1701 McCulloch			25a. DATE REC'D BY REGISTRAR SEP 04 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a qualified physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

184821

184821

184821

184821

061789 AUG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22449

1. FOR
STATE
REGISTRAR

2. DECEASED NAME

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

M

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

7. UNDER 1 YEAR

IF UNDER 24 HRS.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

12a. USUAL OCCUPATION

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

13c. COUNTY

13d. CITY OR TOWN

13e. STREET ADDRESS / ZIP CODE

14. FATHER'S NAME

15. MOTHER'S NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a):

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT HOME AT HOME

21e. PLACE OF INJURY

(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL ☒ DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

23a. PHYSICIAN'S NAME (TYPE OR PRINT)

23b. ADDRESS

23c. BURIAL, CREMATION, REMOVAL

23d. DATE

23e. NAME OF CEMETERY OR CREMATORY

23f. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

26. DATE OF DEATH

27. REGISTRAR'S SIGNATURE

28. DATE OF DEATH

29. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove page 3 and 4 from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

061582 ANG-285

063962 AUG-28-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22450

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NOVELLA ARNOLD			2a. DATE OF DEATH MONTH DAY YEAR 8 20 87			2b. HOUR 2:13 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 23 16		6. AGE (IN YEARS LAST BIRTHDAY) YRS 70		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE 4244 Howerton Road 21229	
14. FATHER'S NAME FIRST MIDDLE LAST Ross		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Rogers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 415-14-2463		17. INFORMANT Shirley Arnold ADDRESS Brown N.Y. Apt 4K 2040 Bruckner Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) aspiration / o. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) metastatic colon carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min 12 hrs. 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION 7/31/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED colon carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Brent C. Birely				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRENT C. BIRELY				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/87		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE Wm. C. March			

MEDICAL CERTIFICATION

0033005 100 50 81

6

0033005 100 50 81

per informant, Soc. Ser. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

063983

AUG 28 87

REG. NO.

22451

1. NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLEN E. ARRINGTON		2a. DATE OF DEATH MONTH DAY YEAR 8/20/87		2b. HOUR 6:27 M	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1/26/51		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD. E.R.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY BULLOCK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLEOPHUS ARRINGTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-58-0769		17. INFORMANT ADDRESS CLEOHUS A. PERRY 2115 DIVISON STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE HUNG CHENG				22c. DATE SIGNED 8/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUNG CHENG				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/29/87		23c. NAME OF CEMETERY OR CREMATORY BROWN FUNERAL SERVICE	
23d. LOCATION CITY OR TOWN WARRENTON		COUNTY N.C.		STATE N.C.	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE 21202				25a. DATE REC'D. BY REGISTRAR AUG 26 1987	
				25b. REGISTRAR'S SIGNATURE Gabe Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

003283 304 88000

003283 304 88000

063251 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. 22452

1. DECEASED NAME (LAST, FIRST, MIDDLE) (Pearley) Pearley M. Arts		2a. DATE OF DEATH MONTH DAY YEAR 8 14 87		2b. HOUR 8:30 P.M.	
3. SEX ♀	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 22 12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.	
10. CITY OR TOWN OF DEATH Balt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FSK		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Balt	13d. STREET ADDRESS / ZIP CODE 2020 E. Chase St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Adger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 246-18-2697		17. INFORMANT ADDRESS Jessie Ervin 2020 E. Chase St.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatic Ca metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE C. Thuren		DEGREE MD		23b. DATE SIGNED 8/14/87	
23c. PHYSICIAN'S NAME (PERSON WHO)		23d. ADDRESS FSK med. Center			
24a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		24b. DATE 8/22/87		24c. NAME OF CEMETERY OR CREMATORY MT AUBURN CEM	
24d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		25. DATE REC'D. BY REGISTRAR AUG 19 1987			
26. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, Blotter Traumatic event, the medical certificate must be completed and filed.

BP

003521 AUG 50 83

AUG 1 9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 4 5 3

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			7b. HOUR			
NICHOLAS P. ARVANITIS						8-17-87						AM			
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	
Male		White		8 14 52		35		MONTHS DAYS		HOURS MIN.		8-17-87		10:38	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
Greece				Greece								Baltimore City MD.			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				824 S. Ponca Street				Hairdresser				Hairdressing			
13a. STATE								13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland										Baltimore		824 S. Ponca Street 21224			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME							
Pete Arvanitis								Anastasia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No								500-76-6855				Mrs. Irene Arvanitis 824 S. Ponca Street, Baltimore, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
				10:05AM 8-17-87				self/inflicted							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				home				824 S. Ponca Street Baltimore, Maryland STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
<i>Margarita A. Korell</i>				Assistant				8-17-87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				8-20-87		Oak Lawn Cemetery				Baltimore Baltimore Md.					
24 FUNERAL DIRECTOR										25a. DATE RECD. BY REGISTRAR					
Annas, Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224										AUG 20 1987					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE WITH THE REGISTRAR. TO FUNERAL DIRECTOR: THIS CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITHIN 24 HOURS AFTER DEATH. TO REGISTRAR: THIS CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITHIN 24 HOURS AFTER DEATH. TO BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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064276 AUG 31 1987

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 REG. NO. 2 2 4 5 4

1. DECEASED NAME (NAME OR PRINT) ASNER LEON NMI ASNER			2a. DATE OF DEATH MONTH DAY YEAR 8 22 87			2b. HOUR MIN. 7 20 A		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 03 27 07			6. AGE (IN YEARS LAST BIRTHDAY) 80			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPRIETOR		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE	13c. CITY OR TOWN REISTERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 317 HOLLY HILL RD. (21136)	
14. FATHER'S NAME FIRST MIDDLE LAST MOSES ASNER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE ROGOFF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-0027A		17. INFORMANT ADDRESS HYMAN ASNER 317 HOLLY HILL RD. (21136)				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMOPTYSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE LEUKEMIA		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 19 87 to 8/22 19 87 , that (I) (we) last saw the deceased alive on 8/22 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Flavio Kruter				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/22/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLAVIO KRUTER			22e. ADDRESS 22 SOUTH GREEN ST BALTIMORE, MD 21201		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/24/87	23c. NAME OF CEMETERY OR CREMATORY MOSES MONTEFIORE	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, BALTO., MD.
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS.		25a. DATE REC'D. BY REGISTRAR AUG 28 1987	
25b. REGISTRAR'S SIGNATURE Julia Gordon Radtke			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the accompanying pages 1 and 2 and place them in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, it may be necessary to have the body examined by a medical examiner.

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63233 AUG 20 1987

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 4 5 5

1. DECEASED NAME (TYPE OR PRINT) BRANDON Keith ATWOOD			2a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR DEATH MATED <input type="checkbox"/> 8-16-87 19			2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 14, 1987	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 2 2	IF UNDER 1 YR. MONTHS DAYS 2 2	IF UNDER 24 HRS. HOURS MIN. 11:10a	2c. DATE PRONOUNCED DEAD 8-16-87 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependant	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1415 Cavendish Way 21224	
14. FATHER'S NAME FIRST MIDDLE LAST James M. Atwood			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dawn Moody			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Gail Moody 1427 Gusryan Street 21224		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Sudden infant death syndrome</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE <u>Margarita A. Korell</u> EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 8-17-87
23a. ADDRESS 111 Penn Street		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-19-87	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Dunda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR AUG 19 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JPM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22456
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude M. Auffarth		2a. DATE OF DEATH MONTH DAY YEAR Aug. 8 1987		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR March 29 1900	
6. AGE (IN YEARS LAST BIRTHDAY) 87		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur C. Heise		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline M. Kissner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 215-07-0581D 214-22-1261		17. INFORMANT Charles H. King 4918 Carroll Ct. Baldwin, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>CORONARY ARTERY DIS</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>POSSIBLE PNEUMONIA, SEVERE DEMENTIA</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased <u>above</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) see the body after death.		22b. SIGNATURE <u>RIVERS</u>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) RIVERS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-10-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.		24. FUNERAL DIRECTOR NAME ADDRESS JOHN C. MILLER Inc. 6415 Belair Rd.		25a. DATE REC'D. BY REGISTRAR AUG 10 1987	
25b. REGISTRAR'S SIGNATURE 1. <u>Richard P. ...</u>					

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AUG 28 1987

Item 13 per phone 8/31/87
 FOR A BALTIMORE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

22457

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARMEN AYANIAN			2a. DATE OF DEATH MONTH DAY YEAR 8/13/87		2b. HOUR 11:07 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 14 1928		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES PERSON		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ELISHA AYA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARAMNEH TORYKIAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. 097-22-8220	
17. INFORMANT ADDRESS Dr. Ayanian - brother		17. INFORMANT ADDRESS 859-1333		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>undue stress</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 <u>Multiple sclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> , 19 <u>87</u> , to <u>8/13</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Peter Cheng</u> MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER CHENG		22e. ADDRESS 14711 VALANT TOWN BAYTON RD MD 2086					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-21-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Henderson</u>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3 and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

17

1. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. It is well written and easy to read.

2. The second part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

3. The third part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

4. The fourth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

5. The fifth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

6. The sixth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

7. The seventh part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

8. The eighth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

9. The ninth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

10. The tenth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. It is well written and easy to read.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 32458

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Arnold				Bacon		JR.		8/ 28/ 19 87		8/		28/		19 87		5:03 P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	BLACK	8 27 1947		40 YRS.						8/ 28/ 19 87							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		U. S. A.		WIDOWED		DIVORCED		Baltimore City,								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Francis Scott Key Medical Center		SECURITY GUARD		COMM. COLLEGE											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND				BALTIMORE		YES X NO		4307 ADELLE TERR. 21229									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
ARNOLD		BACON		MARGARET WASHINGTON		BACON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		216-48-8295		MRS. PATRICIA BACON		BALTO. MD. 21229											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		Ruptured Berry Aneurysm with Subarachnoid Hemorrhage															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		Secondary to Hypertension															
(b)		DUE TO, OR AS A CONSEQUENCE OF															
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES X NO													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I had charge of the remains described above, held in death resulted from		Autopsy X Inspection Inquiry and in my opinion															
Natural causes X Accident Suicide Homicide Undetermined manner																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
John E. Smialek, M.D.		Chief		8/29/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John E. Smialek, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		9/2/87		WESTERN STAR CEM.		BALTIMORE, MD.											
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
NOTTER FUNERAL HOMES, INC.		SEP03 1987		Julia Davidson-Randall													
2501 GWYNNS FALLS PKWY, BALTO. MD. 21216																	

07/84
25MA

BP

DHMH - 17
(VR A15 ME (5))

024718 SEP-48

25

MADE IN
CHINA

MADE IN
CHINA

20% COTTON



MADE IN
CHINA

SEP03 1948

062625 AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 4 5 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		2b. HOUR	
Charles F. Bailey								8		6		19		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	10/17/13		73 YRS.		MONTHS		DAYS		HOURS		MIN		8		7 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		201 N. Broadway		Retired													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		201 N. Broadway St Apt 17 L									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST			
Charles F. Bailey								Victory Bailey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		219-16-4311		Williams H. Bailey		1516 W. Strickland St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <u>Charles P. Kokes</u>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 8/7/87											
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.		ADDRESS		111 Penn St. Balto.MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		8/11/87		Mt. Zion Cemetery		Lansdowns A.A. Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Charles A. Rice		FSPA 1300 Eutaw Pl.		AUG 12 1987		Julia Gordon-Rodwell											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

085852 AUG 13 87

30% COTTON 100% COTTON

110

110



AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22460

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR

08 - 10 - 87 3:45 P.M.

1 - FOR
STATE
REGISTRAR

DECEASED NAME

(TYPE OR PRINT)

FIRST MIDDLE LAST

DONALD BAILEY

3 SEX

Male

4 RACE

Negro

5 DATE OF BIRTH

MONTH DAY YEAR 8-19-28

6 AGE (IN YEARS LAST BIRTHDAY)

58

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

M.D.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

BALTO.

MD.

10 CITY OR TOWN OF DEATH

BALTO.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Liberty Medical Center

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Nursing Asst.

12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

M.D.

13b. COUNTY

-

13c. CITY OR TOWN

BALTO

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

3000 Reisterstown Rd 21215

14 FATHER'S NAME

FIRST MIDDLE LAST

VERNON

MIDDLE

BAILEY

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST

RUBY

MIDDLE

WOODVILLE

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

216-20-5336

17 INFORMANT

OLIVA CHANEY

ADDRESS

3000 Reisterstown Rd

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) SHOCK

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

(c) PNEUMONIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

RESPIRATORY FAILURE - RENAL FAILURE - MYOCARDIAL INFARCTION

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHERE AT WORK ☐ NOT WHERE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)

21f LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 07-26 19 87 to 8/10 19 87, that (I) (we) last saw the deceased alive on 8/10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

BICH T DUONG

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c DATE SIGNED

8-10-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

BICH T DUONG

22e ADDRESS

LIBERTY MEDICAL CENTER

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

8/15/87

23c NAME OF CEMETERY OR CREMATORY

BALTO. Cem.

23d LOCATION CITY OR TOWN

BALTO.

COUNTY

STATE

M.D.

24 FUNERAL DIRECTOR

NAME

ADDRESS

BETH'S FUNERAL HOME 1129 N. CAROLINE ST

25a DATE REC'D. BY REGISTRAR

AUG 14 1987

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

005200-INC 15 81

200-2-1000
200-2-1000

100-1-1000

062812

AUG 14 87
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 REG. NO. 2 2 4 6 1
20. DATE OF DEATH MONTH DAY YEAR 8-11-87 6 30 A M

1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED MIDDLE LOUISE LAST BAILEY		20. DATE OF DEATH MONTH DAY YEAR 8-11-87 6 30 A M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 04-05-20	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAVEN NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY CARROLL	13c. CITY OR TOWN UNION BRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN OILER	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MCKENZIE	16. SOCIAL SECURITY NO. 213-64-7234	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	17b. INFORMANT ADDRESS NANCY SPENCE 4256 FSK HWY. TANETOWN, MD	17c. SOCIAL SECURITY NO. 213-64-7234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Senile dementia.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 19 86 to August 12 19 87 that (I) (we) last saw the deceased alive on July 30th 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death.			
22b. SIGNATURE [Signature]	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-11-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge F. Ochoa-Smith M.D.	22e. ADDRESS 303 N. Rolling Rd. Baltimore, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	8/14/87	Resthaven Mem. Gardens	Frederick Frederick MD
24. FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 13 1987 Julia Tendon-Lindner	

085815 VNG 14 01

ESTABLISHED 1900

1900-00-00

1900-00-00

1900-00-00

1900-00-00

1900-00-00

1900-00-00

1. FOR STATE SB oer funeral home REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 2 4 6 2

REG. NO.

1. DECEASED NAME (PRINT) ANGELA T. BALAKIER			7a. DATE OF DEATH MONTH DAY YEAR AUGUST 23, 1987		7b. HOUR 9:58p m			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 6 21 19		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OF FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA MARC		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 017-07-4719		
17. INFORMANT NAME ADDRESS MR. JOSEPH BALAKIER SAME		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASYSTOLE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE MYOCARDIAL INFARCTION, HYPOXIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MYOCARD ISCHEMIA, CARDIAC ARRHYTHMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 AM HRS HRS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>PREVIOUS MYOCARDIAL INFARCTION, ADULT ONSET DIABETES MELLITUS, ARRHYTHMIA</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>AUGUST 23, 19 87</u> to <u>AUGUST 23, 19 87</u> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>August 23, 19 87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.								
22b. SIGNATURE John F. Marra M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. MARRA M.D.		22e. ADDRESS c/o MARYLAND GENERAL HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8.26.87		23c. NAME OF CEMETERY OR CREMATORY Holy ROSARY Cem		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		
24. FUNERAL DIRECTOR Kaczorowski F. Home		ADDRESS 5505 Fleet St.		25a. DATE REC'D. BY REGISTRAR AUG 25 1987		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MARYLAND 21201

BP 16

0000000000000000

062438 AUG 12 1987


Item #5,6 G 630 E/18/87 CW STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REG. NO. 22463

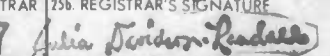
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THEODORE BALCEROWICZ			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 9 19 87		2b. HOUR M 3:32 P M
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 10 7 19 47	6. AGE (IN YEARS) LAST BIRTHDAY 40 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 9 19 87	
7a. BIRTHPLACE (STATE OR COUNTY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b. STREET ADDRESS 4739 Scholor Rd 31222		13c. CITY OR TOWN BALTIMORE		13d. STATE MARYLAND	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW BALCEROWICZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA BULCZYNSKI		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT MR ANTHONY BALCEROWICZ		17. ADDRESS SAME	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant glioma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 18

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 8-11-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8-13-87		23c. NAME OF CEMETERY OR CREMATORY Holy Rysary Cem.	
23d. LOCATION BALTIMORE Co. MD.		24. FUNERAL DIRECTOR NAME KACZOROWSKI		25a. DATE REC'D. BY REGISTRAR AUG 11 1987	
24. ADDRESS FUNERAL HOME Fleet St.		25b. REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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APR 15 1991

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22464
08-03-87 10:43 P M

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIGAH WARNER BALL				2a. DATE OF DEATH MONTH DAY YEAR 08-03-87				2b. HOUR 10:43 P M			
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 9 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 72 HRS. HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LONGSHOREMAN		12b. KIND OF BUSINESS OR INDUSTRY ---	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BALTO. MD. 1403 POPLAR GROVE 21216	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATSY WILLIAMS				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWI			
16b. SOCIAL SECURITY NO. 217-01-3920				17. INFORMANT BARBARA DANCE				ADDRESS BALTO. MD. 1403 POPLAR GROVE ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK, CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVP											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RESPIRATORY FAILURE. SEPSIS - PNEUMONIA											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/3 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-27 19 87 to 08/03 19 87 , that (I) (we) last saw the deceased alive on 8/3 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bich T Duong				DEGREE M.D. - ATTENDING PHYSICIAN				MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG				22e. ADDRESS LIBERTY MEDICAL CENTER							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/8/1987		23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL HOME NAME ADDRESS QUINCY FUNERAL HOMES, INC., 2501 GWYNNS FALLS PKWY, BALTO, MD, 21216				25a. DATE REC'D. BY REGISTRAR AUG 12 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

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08250 WUE 13 01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the depth certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove crumpled papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Ruth		MIDDLE Jones		LAST Barber		2a. DATE OF DEATH		MONTH 8		YEAR 87		2b. HOUR M									
3. SEX Male		4. RACE Black		5. DATE OF BIRTH		MONTH 3		DAY 21		YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilson Co Ala		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY		12. MONTHS		13. DAYS									
10. BALTIMORE CITY OR COUNTY OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 812 W Fayette St		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 21201		13b. CITY OR TOWN Baltimore		13c. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME FIRST Wade		MIDDLE Jones		LAST Francis		15. MOTHER'S MAIDEN NAME FIRST Francis		MIDDLE Wright		LAST Cleveland		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 369-26-1590									
17. INFORMANT Robert Jones		ADDRESS 4124 E 155 St		Cleveland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced congestive cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>History pulmonary embolus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>85</u> , to <u>8</u> 19 <u>87</u> , that (I) (we) lost saw the deceased <u>above</u> <u>(I) (we) (did) (did not) view the body after death.</u>		22b. SIGNATURE CD Kearney MD		22c. DATE SIGNED							
22a. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER D. KEARNEY		22b. ADDRESS 700 W 101 BLVD BALTIMORE MD 21230		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION BALTIMORE		22e. DATE REC'D BY REGISTRAR AUG 11 1987		22f. REGISTRAR'S SIGNATURE J. P. [Signature]		22g. BURIAL, CREMATION, REMOVAL Burial		22h. DATE 8/12/87		22i. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22j. LOCATION BALTIMORE		22k. COUNTY Maryland		22l. STATE Maryland	
24. FUNERAL DIRECTOR NAME James A. Martin		ADDRESS 1701 Laurens		25a. DATE REC'D BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE J. P. [Signature]		25c. BURIAL, CREMATION, REMOVAL Burial		25d. DATE 8/12/87		25e. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		25f. LOCATION BALTIMORE		25g. COUNTY Maryland		25h. STATE Maryland					

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FOR Item 8 Film G630 8031-87
STATE Per funeral Home Sp
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 4 6 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Clarence		Alexander		Barksdale				8		25		19		87		M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	11 13 1916		70 YRS.		MONTHS		DAYS		8		25		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. Separated		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital		Paper Hanger		Realty Co.,											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1517 W. Fayette Street									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Robert		Lucy															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		218-10-3633		Mrs. Michelle L. Davis		Baltimore, Md. 21239											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
8902		Smoke and soot inhalation															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Arteriosclerotic cardiovascular disease															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
7:28 P.M.		8 25 1987		House fire													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
home		1517 W. Fayette St., Balto.															
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Mario F. Golle, Jr.		M.D. Assistant		8/26/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Mario F. Golle, Jr., M.D.		111 Penn St. Balto. MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		8/31/1987		Garrison Forest Vet. Cem.		Baltimore, Maryland											
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
NIGHTER FUNERAL HOMES, INC.		AUG 28 1987															
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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WILKINSON BOND



WILKINSON BOND

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AUG 21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

22467

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL T. BARNES			2a. DATE OF DEATH MONTH DAY YEAR 08 16 87			2b. HOUR 12.30 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3/6/1921		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secure Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. STATE MD.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Chaptico		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Barnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Short		13e. STREET ADDRESS / ZIP CODE P.O. Box 132/20621			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216 12 4178		17. INFORMANT Niece ADDRESS 7269 Woodhollow Ft. Washington, MD. 20744			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL CANCER SECONDARY FROM DUE TO, OR AS A CONSEQUENCE OF CANCER OF COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 05/13		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 08/16 87			
22a. I certify that (I) (the hospital) attended the deceased from 8/16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kuang-yen Huang				DEGREE M.D.		22c. DATE SIGNED 08/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG				22e. ADDRESS BON SECOURS Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/87		23c. NAME OF CEMETERY OR CREMATORY Queen of Peace Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Helen STM MD.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtown, MD.		25a. DATE REC'D BY REGISTRAR AUG 20 1987	
				25b. REGISTRAR'S SIGNATURE Leonardtown			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

003305 W05 51 83



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1- STATE
REGISTRAR

REG. **22468**

063512

AUG 24 87

2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2c. HOUR	
		8 18 87				8 18 87		7:03P	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		
F	W	NOV. 21, 1986		8 YRS.	8 MONTHS 27 DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.		WIDOWED		DIVORCED		Baltimore City, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Johns Hopkins Hospital							
13a. STATE					13b. COUNTY				
Md					BALTIMORE				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
ALBERT TRUFFER					MICHELLE BARNHART				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.				
NO					NONE				
17. INFORMANT					ADDRESS				
MICHELLE BARNHART					6208 Old Harford Rd				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY: **9104 Drowning**

IMMEDIATE CAUSE (a) **DUE TO, OR AS A CONSEQUENCE OF**

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) **DUE TO, OR AS A CONSEQUENCE OF**

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	910xxx 8 17 87	Subject drowned in bathtub
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION
	house	6208 Old Harford Rd, Balto. MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE **Mario F. Golle, Jr.** TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **8/19/87**

EXAMINER'S NAME (TYPE OR PRINT) **Mario F. Golle, Jr., M.D.** ADDRESS **111 Penn St. Balto.MD.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	AUG 20, 1987	GREEN MOUNT	BALTIMORE		MD.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HARTLEY MILLER		AUG 21 1987		Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 22469
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIVIA J. Basket			2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR 8 24 87 0645A M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 08 04 16	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS- LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Umms		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? MD Baltimore YES		12b. KIND OF BUSINESS OR INDUSTRY House work		13e. STREET ADDRESS / ZIP CODE 1100 N. Woodyear 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Jefferson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST house		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-24-7656		17. INFORMANT ADDRESS Janie Burrell 2421 Westwood Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) malignant Ascites DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 8-24-87, 19 87, that (I) (we) lost the deceased above on 8/23/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul Rogers MD				22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/29/87		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY MD		23f. STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR AUG 26 1987	
				25b. REGISTRAR'S SIGNATURE John Davidson	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22470
REG. NO.1. FOR
STATE
REGISTRAR2. DECEASED NAME
(TYPE OR PRINT)

FIRST MARY

MIDDLE S.

LAST BATER

2a. DATE OF DEATH MONTH DAY YEAR 8 20 87 2b. HOUR 2157 M

3. SEX F

4. RACE B

2

5. DATE OF BIRTH

MONTH DAY YEAR 1 20 20

6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PORTSMOUTH VA.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH CITY OF BALTIMORE MD

10. CITY OR TOWN OF DEATH BALT

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE MD

13c. COUNTY BALT

13d. CITY OR TOWN BALT

13e. INSIDE CITY LIMITS? YES ☒ NO ☐

13f. STREET ADDRESS / ZIP CODE

4615 PARK HEIGHTS AVE 21218

14. FATHER'S NAME

FIRST MIDDLE LAST FODIE HURCHERSON

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST MARY JANE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

16b. SOCIAL SECURITY NO. 005006040

17. INFORMANT

ADDRESS IRVING SYKES 2633 ASQUITH ST

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

gangrenous limb

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/18, 19 87, to 8/20, 19 87, that (I) (we) last saw the deceased alive on 8/20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

S. A. LAZAROU

22e. ADDRESS

SINAI HOSP.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Bereavement

23b. DATE

8/24/87

23c. NAME OF CEMETERY OR CREMATORY

Mt Calvary

23d. LOCATION

Baltimore, Maryland

24. FUNERAL DIRECTOR

NAME ADDRESS Plan Ball & Hays 6350 91/now st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 10M. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22471					
1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)			FIRST Georgette			MIDDLE E.			LAST Batsis			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8/ 19/ 87		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11/15/99		6. AGE (IN YEARS) (LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8/ 19/ 87		2d. HOUR 6:36 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3501 St. Paul St. # 1102				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beauty Operator				12b. KIND OF BUSINESS OR INDUSTRY Beauty			
13a. STATE MD				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3501 St. Paul St., 21218				Shop	
14. FATHER'S NAME FIRST MIDDLE LAST Pierre Dequin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Thibert				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 351 07 6664		17. INFORMANT ADDRESS Pierre E. Berry, Balto., MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 8/20/87			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 8/20/87				23c. NAME OF CEMETERY OR CREMATORY Green Mount				23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD			
24. FUNERAL DIRECTOR NAME H.W. Jenkins, 21212				25a. DATE REC'D. BY REGISTRAR AUG 21 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Eason-Randall</i>							

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FOR
1. STATE
REGISTRAR
AUG 26 1987STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 4 7 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marcel Joseph Bawroski			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1987		2b. HOUR 12:15 ^P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11/12/13	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD		
12. CITY OR TOWN OF DEATH Baltimore	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3908 Pennington Avenue		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Steel Work	15. KIND OF BUSINESS OR INDUSTRY Kopper's	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3908 Pennington Ave., 21226
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bawroski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agatha ---			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-03-2101	17. INFORMANT Wife Rose Bawroski		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>---</u>					
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ---		21f. LOCATION STREET CITY OR TOWN COUNTY STATE --- Baltimore ---	
22a. I certify that (I) (his hospital) attended the deceased from <u>10-11</u> , 19 <u>82</u> , to <u>8-20</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6-2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Sue Thompson MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sue Thompson, M.D.		22e. ADDRESS 3819 Potee St., Balto., Md. 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/24/1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A.A., Md.		
24. FUNERAL DIRECTOR NAME McCully Funeral Homes		24b. ADDRESS 237 E. Patapsco Ave., Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR AUG 25 1987	25b. REGISTRAR'S SIGNATURE <u>John T. Fisher</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

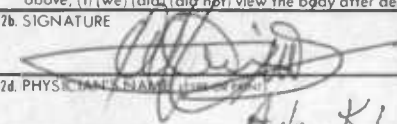
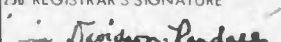
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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AUG 28 81

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FOR
STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22413
22473
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES HAROLD BAYNE			2a. DATE OF DEATH MONTH DAY YEAR 08 31 87		2b. HOUR 1:50 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 09 20 36		6. AGE (IN YEARS (LAST BIRTHDAY)) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTIMORE GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY HANDYMAN
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 114 W. Astend ST. Balto. Md. 21230
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH Parks BAYNE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HABEL M. RICKEHL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219-28-3621		17. INFORMANT ADDRESS HOSPITAL RECORDS 3001 S. HANOVER ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) & CEREBROVASCULAR ACCIDENT					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a EXCESSIVE ALCOHOL ABUSE HISTORY					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 22 AUGUST 19 87 to 31 AUGUST 19 87 that (I) (we) last saw the deceased alive on 31 AUGUST 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/31/87
22d. PHYSICIAN'S NAME (Last, First, Middle) A.H. KLEIN		22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/1987	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard, Md.
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230			25a. DATE REC'D. BY REGISTRAR SEP 1 1987		
			25b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35473

004212 SEP-58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22474

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. DATE OF DEATH		4. HOUR	
RANDALL		BEAVER		AUGUST 5, 1987		8:25A M	
5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		6. CITIZEN OF WHAT COUNTRY?		7. DATE OF BIRTH		8. AGE (IN YEARS LAST BIRTHDAY)	
Tennessee		USA		12/30/44		42 YRS.	
9. CITY OR TOWN OF DEATH		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		11. BALTIMORE CITY OR COUNTY OF DEATH		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		BALTIMORE CITY		MD.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14. STATE		15. CITY OR TOWN		16. INSIDE CITY LIMITS?	
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		706 S. Marlyn Ave, 21221	
17. FATHER'S NAME		18. MOTHER'S MAIDEN NAME		19. ADDRESS		20. SOCIAL SECURITY NO.	
Paris Beaver		Thelma Beaver		Lorrana Beaver 706 S. Marlyn Ave.		214-44-0730	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		22. SOCIAL SECURITY NO.		23. INFORMANT		24. ADDRESS	
no		214-44-0730		Lorrana Beaver		706 S. Marlyn Ave.	
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) BRAIN HERNIATION							
DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN METASTASIS							
DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCYSTIC CA OF NASOPHARYNX							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY?		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		33. DATE SIGNED	
		HOUR A.M. MONTH DAY YEAR				8/5/87	
34. INJURY OCCURRED		35. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		36. LOCATION		37. COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN		STATE	
22. I certify that (I) (this hospital) attended the deceased from		AUGUST 1, 19 87, to		AUGUST 5, 19 87, that (I) (we) lost		38. DATE REC'D. BY REGISTRAR	
saw the deceased alive on		AUGUST 5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		above, (I) (we) (did) (did not) view the body after death.		39. REGISTRAR'S SIGNATURE	
40. SIGNATURE		DEGREE		41. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		42. ADDRESS	
MARY G. BOLTON		MD		600 N. WOLFE ST. BALTO., MD		21205	
43. BURIAL, CREMATION, REMOVAL (SPECIFY)		44. DATE		45. NAME OF CEMETERY OR CREMATORY		46. LOCATION	
Cremation		8/6/87		Westview Crematory		Catoonsville, Md.	
47. FUNERAL DIRECTOR		48. NAME		49. ADDRESS		50. DATE REC'D. BY REGISTRAR	
Charles A. Rice FSPA		1300 Eutaw Pl,				AUG 06 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST GRACE L. Bedford			2a. DATE OF DEATH MONTH DAY YEAR 8 26 87		2b. HOUR 250 A.M.
3. SEX Female	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 13 23		6. AGE (IN YEARS (LAST BIRTHDAY)) 64	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2008 Pulaski St. BALTO. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Percy Blackwell	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hycyntha Jones		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
16a. SOCIAL SECURITY NO. 216-20-6261		17. INFORMANT JAMES E. BEDFORD, JR. 2008 N. PULASKI			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA 7 stomach with DUE TO, OR AS A CONSEQUENCE OF Liver & abdominal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Metastasis DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/19 , 19 87 , to 8/26 , 19 87 , that (I) (we) lost saw the deceased alive on 8/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Helen A. [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Sabunsky		22e. ADDRESS Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/29/87	23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VET.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.
24. FUNERAL HOME OR NAME 2501 GWYNNS FALLS PKWY, BALTO. MD, 21216			25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or if a medical examiner was called, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22470

REG. NO.

FOR
1. STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Cecil C. BELCHER			2a. DATE OF DEATH MONTH DAY YEAR August 25, 1987		2b. HOUR 8:30 AM
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 06/14/28		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Veterans Administration Medical Cntr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool maker	12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Street	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Absalom Belcher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 217 20 9677		17. INFORMANT ADDRESS E. Jean Belcher 3214 Old Forge Hill Road Street, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lung Cancer with Brain Metastases</u> 8 months DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Metastases</u> Smoking 40 years 8 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (i)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>August 15</u> , 19 <u>87</u> , to <u>August 25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
23. SIGNATURE <u>Jeff Williamson</u>		DEGREE M.D.		22c. DATE SIGNED	
21. PHYSICIAN'S NAME (TYPE OR PRINT) Jeff WILLIAMSON,		22e. ADDRESS 3900 Loch Raven Blvd., Balto., MD 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/28/87	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Peach Bottom Twp., York, PA	
24. FUNERAL DIRECTOR NAME Harkins Funeral Home, Inc.		ADDRESS 600 Main St. Delta,		25. DATE REC'D. BY REGISTRAR SEP 02 1987	

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(VRA 15, 4)

084252 SEP-301

RECEIVED



SEP03 1991

063767 AUG 26 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

22-77

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST JOHN R. BELT		2. DATE KNOWN OF DEATH MONTH DAY YEAR 8-23-87		7. HOUR M 4:30 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 23 61	6. AGE (IN YEARS) (LAST BIRTHDAY) 26 YRS.	IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-23-87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Dept.		12b. KIND OF BUSINESS OR INDUSTRY Marriott		13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Carroll Hampstead	
14. FATHER'S NAME FIRST MIDDLE LAST A. Lylle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Bull		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	
17. SOCIAL SECURITY NO. 216-80-2349		18. INFORMANT Mr. A. Lylle Belt, Jr.,		19. ADDRESS Md. Hampstead	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:43 PM 8-21-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot (REAR)		21f. LOCATION CITY OR TOWN COUNTY STATE 3125 Church Street Carroll Co., Maryland	
22a. I certify that I took charge of the remains described (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 8-24-87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-26-87	23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md.		25a. DATE REC'D BY REGISTRAR AUG 25 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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063337 AUG 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22478
REG. NO.FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNA BENDER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 17, 1987		2b. HOUR 2P M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR FEB. 25, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2500 W. BELVEDERE AVE., APT. 202		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME (21215)	
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JACOB PINCUS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-32-9742		17. INFORMANT ADDRESS BURNETT BENDER 4212 FALLSTAFF RD. (21215)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF COLON</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>DEC</u> 19 <u>85</u> , to <u>106</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) sign the body after death.					
22b. SIGNATURE <u>Harry H. Walen MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8/18/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARRY H. WALEN MD</u>				22e. ADDRESS <u>4000 Old Court Rd Suite 300 21208</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/18/87	23c. NAME OF CEMETERY OR CREMATORY MONTEFIORE CEMETERY	23d. LOCATION PHILADELPHIA COUNTY PA. STATE
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215		25a. DATE REC'D. BY REGISTRAR AUG 20 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

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Aug 20 1937

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22479

REG. NO.

1. DECEASED NAME (PRINT) Emma R. Bender		2a. DATE OF DEATH MONTH DAY YEAR 8-15-1987		2b. HOUR 18:00 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12-8-1895		6. AGE (IN YEARS LAST BIRTHDAY) 91	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3101 Glenmore Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Reid		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Barger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 174-10-9848		17. INFORMANT Forest Hill, Md. 21050 Josephine Gettier, 1826 Cosner Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ARTERIO-SCLEROTIC CORONARY VASCULAR DISEASE, PROBABLE FRACTURE OF HUMERUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Michael Niehoff</i>		DEGREE MD		22c. DATE SIGNED 8/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Niehoff, M.D.		22e. ADDRESS 9000 Franklin Square Dr.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-18-87		23c. NAME OF CEMETERY OR CREMATORY Moreland	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		23e. DATE REC'D. BY REGISTRAR AUG 18 1987			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.		25. REGISTRAR'S SIGNATURE <i>John Davidson-Rodale</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medicolegal examiner must be notified of this.

BP _____

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 4 8 0

1. DECEASED NAME (TYPE OR PRINT) Mildred N. BENJAMIN			2a. DATE OF DEATH MONTH DAY YEAR 08 19 87		2b. HOUR 1205 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 07 07 1905		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---				
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 506 S. Wickham Road, 21229				
14. FATHER'S NAME FIRST MIDDLE LAST Charles Benjamin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carvella Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-24-1042		17. INFORMANT ADDRESS Mildred Mann, 506 S. Wickham Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sigmoid Diverticulitis ± Abscess DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Perforated Gastric Ulcer ± Abscess DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Pulmonary arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-28/87 → 8/19 7/30/87 → 8/19						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION 6/29/87 + 7/30/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex. plastron, Sigmoid resec; perfr. Stomach		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/19 19 87 , to 8/19 19 87 , that (I) (we) last saw the deceased alive on 8/19 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE P. Ledoux		DEGREE M.D.		22c. DATE SIGNED 8/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Ledoux		22e. ADDRESS 900 caton ave St Agnes hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md.						
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D BY REGISTRAR AUG 24 1987		
25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove signature papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22481
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BELLAH J. BENNETT			2a. DATE OF DEATH MONTH 8 DAY 29 YEAR 87		2b. HOUR 2:45 P.M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 02 DAY 08 YEAR 44		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3514 Reisterstown Rd 21215
14. FATHER'S NAME FIRST Henry MIDDLE LAST Rabb		15. MOTHER'S MAIDEN NAME FIRST Kethe MIDDLE LAST Bennett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-44-1473		17. INFORMANT Bridget Harris ADDRESS 3514 Reisterstown Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Angio Sarcoma of Nasopharynx DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 METASTASIS & SPREAD OF CANCER CELLS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chandrasekhar Singh		DEGREE		22c. DATE SIGNED 8/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDRASEKHAR SINGH		22e. ADDRESS UNIV OF Maryland (FHC)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/4/87	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN Arbutus COUNTY Md	23e. DATE REC'D. BY REGISTRAR SEP 03 1987
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West ADDRESS 4300 Wabash Avenue				25b. REGISTRAR'S SIGNATURE W. C. March	

BP

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Amount

32.11

On account of 1/2 business trip
to New York City
on 10/10/48

Travel expenses

10/10/48

10/10/48

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22482
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth D. Bennett			2a. DATE OF DEATH MONTH DAY YEAR 8 9 87			2b. HOUR 6:30 P.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 9 1901		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesley Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2211 West Rogers Ave. 21209	
14. FATHER'S NAME FIRST MIDDLE LAST Frances S. Dall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kata W. Stewart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-30-9890		17. INFORMANT ADDRESS Mrs. Elizabeth Gladstone 1902 Northleigh Rd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suspected Gastros Intestinal CA.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Peripheral neuropathy, SIP CA Encephalopathy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 8/9 , 19 71 , to 8/9 , 19 87 , that (I) (we) last saw the deceased alive on 8/9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE Robert Liberto, M.D.						22c. DATE SIGNED 8-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Liberto				22e. ADDRESS 3508 Bank Street 21214			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/11/87		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd.				25a. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE Lia Decker-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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064260 AUG 31 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22483

1. FOR STATE REGISTRAR		DECLAISE NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
		Nelson				Bennett	8-21		8	21	1987	3			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR				
MALE	BLACK	8 15 1912	75 YRS.			8-21		8	21	1987	8:09 A.M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
N. CAROLINA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City		MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		1601 N. Rosedale Street				LABORER		BETH STEEL		CO.					
13a. STATE												13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND													BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	BALTIMORE, MD. 1601 N. ROSEDALE ST. 21216
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST WALTER BENNETT				FIRST MIDDLE LAST MARY JANE DIGGS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT							
NO.				242-07-3736				MRS. IDA M. BENNETT 1601 N. ROSEDALE ST.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CC: Sick cell disease, diabetes mellitus															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I have charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE				TITLE (SPECIFY) Assistant				DATE SIGNED				8-21-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Charles P. Kokes, M.D.				111 Penn Street, Balto., MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL				8/25/1987		CEDAR HILL CEMETERY				BALTIMORE, MD.					
24. FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS. PKWY. BALTO. MD. 21216				AUG 28 1987				John Davidson-Rodell							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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064258 AUG 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22487
20. DATE OF DEATH MONTH DAY YEAR 08/21/87 21. HOUR 1135 M1. DECEASED NAME FIRST MIDDLE LAST
OZNO ELIZABETH BENNETT

2. SEX FEMALE 3. RACE BLACK 4. DATE OF BIRTH MONTH DAY YEAR 7 27 1908 5. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 6b. CITIZEN OF WHAT COUNTRY? U. S. A. 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.

9. CITY OR TOWN OF DEATH BALTIMORE CITY 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL 11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAFETERIA AIDE PUBLIC SCHOOLS 12. BALTO CO.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND 13b. COUNTY BALTO 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS BALTIMORE, MD. 323 WINTERS AVE. 21228

14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM LEWIS 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA PURVEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO. 16b. SOCIAL SECURITY NO. 215-34-9276 17. INFORMANT MR. CYRIL BENNETT ADDRESS BALTO. MD. 21228 1105 ARUNAH AVENUE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarctionDUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Acute pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(c) Electro mechanical dissociation

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/19/87 19 87, to 8/21 19 87, that (I) (we) last saw the deceased alive on 8/21 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED 8/21/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ahmad Hossari 22e. ADDRESS St Agnes Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 8/25/87 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.

24. FUNERAL HOME FUNERAL HOMES, INC. 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

2501 GWYNNS FALLS PKWY. BALTO. MD. 21216 AUG 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

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WILEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the Division of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

062911 - AUG. 17-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22485

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMILY GRACE BENZINGER			2a. DATE OF DEATH MONTH DAY YEAR JULY 17 1987		2b. HOUR 7:06 AM
3. SEX FEMALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR JULY 24 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John M. Bromley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva B. Ellis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-12-9285A		17. INFORMANT ADDRESS Mr. John C. Benzinger, Jr. 7818 Daniels Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. J. Hart				22c. DATE SIGNED 7/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. J. HART				22e. ADDRESS GSH	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/20/87	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Road 21214			25a. DATE REC'D. BY REGISTRAR JUL 20 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP

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063974 AUG 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22486
REG. NO.

2a. RECORDED NAME (PRINT) FIRST MIDDLE LAST ROBERT Rennet BERAN			2b. DATE OF DEATH MONTH DAY YEAR AUGUST 25, 1987		2c. HOUR 4:45P M		
3. SEX Male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 07 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crain Operator		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbra Reh		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO 216-07-6736	
17. INFORMANT ADDRESS Dolores M. Mainor 122 S. Symington.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracranial Bleed</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>48 hours.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	

22a. I certify that (I) this hospital attended the deceased from August 23, 1987, to August 25, 1987, that (I) saw the deceased alive on August 25, 1987, and that (my) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE Eric Brown MD		22c. DATE SIGNED 8/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Brown MD		22e. ADDRESS Johns Hopkins Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/28/87		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Mark A. Chojnacki F.H. 1800 E. Lombard St				25. DATE REC'D. BY REGISTRAR AUG 26 1987		26. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified to the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22487

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY W. MIDDLE BERNARD LAST BERNARD		2a. DATE OF DEATH MONTH DAY YEAR 8-18-87		2b. HOUR 7:30 AM	
3. SEX Female		4. RACE White C		5. DATE OF BIRTH MONTH DAY YEAR 11-3-07	
7a. BIRTHPLACE 1 STATE OR FOREIGN Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 79 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairmount NSC center		9. BALTIMORE CITY OR COUNTY OF DEATH City - Baltimore, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife - Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE md		13b. COUNTY ---		13c. CITY OR TOWN BALTO	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8 N Ellwood Ave 21224			
14. FATHER'S NAME FIRST BERNARD MIDDLE --- LAST FERNING		15. MOTHER'S MAIDEN NAME FIRST CATHERINE MIDDLE --- LAST KRAUS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218 05 1449		17. INFORMANT Mrs. Lillian Z. Brown 2028 E. Pratt St. - Balto., Md. 21231	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Actual Fib.illation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from July 6, 19 87, to August 18, 19 87, that (I) (we) last saw the deceased alive on August 18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE C. Vengara-Soares	
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Vengara-Soares		22e. DATE SIGNED	
22f. ADDRESS 100 N. BROADWAY BALTO. MD. 21231		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/20/87	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus - Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home ADDRESS 3000 E. Baltimore St., Balto. Md. 21224		25. DATE REC'D. BY REGISTRAR AUG 19 1987		26. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22488

REG. NO.

FOR
1. STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

Samuel Bernstein

2a. DATE OF DEATH MONTH DAY YEAR 08-04-87 2b. HOUR 4:30 P.M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR 5 28 12

6. AGE (IN YEARS LAST BIRTHDAY)

75 YRS

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto

7b. CITIZEN OF WHAT COUNTRY?

USA

MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Balto City MD

10. CITY OR TOWN OF DEATH

Balto

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Levin Dale

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

XXXXXX Sales man

12b. KIND OF BUSINESS OR INDUSTRY

LAND

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Balto

13c. CITY OR TOWN

Pikesville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1007 SCOTTS HILL DR. #21208

14. FATHER'S NAME

ADOLPH

MIDDLE

BERNSTEIN

15. MOTHER'S MAIDEN NAME

FANNIE

MIDDLE

ROTHMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO No

16b. SOCIAL SECURITY NO.

216-14-3397

17. INFORMANT

MRS. EDITH BERNSTEIN

1007 SCOTTS HILL DR. #21208

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ca Brain with metastases

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7/85

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/22 19 87, to 8/4 19 87 that (I) (we) lost saw the deceased alive on 8/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

8/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

B. ZAWLIN, MD

22e. ADDRESS

Levin Dale 6810 Mt Zion Rd Balto 21245

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

AUG. 6, 1987

23c. NAME OF CEMETERY OR CREMATORY

BALTIMORE HEBREW

23d. LOCATION CITY OR TOWN COUNTY STATE

REISTERSTOWN BALTO. MD

24. FUNERAL DIRECTOR NAME

Sol LEVINSON & Bros

ADDRESS

6010 Reisterstown Rd

25a. DATE REC'D. BY REGISTRAR

AUG 12 1987

25b. REGISTRAR'S SIGNATURE

Julia Dindon-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please enclose this page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

062104 AUG 10 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This document may give certain papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22489
REG. NO.

FOR REGISTRATION REGISTRAR SAMUEL L. BERTOLET				87 22489 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL L BERTOLET				2a. DATE OF DEATH MONTH 8 DAY 6 YEAR 87 2b. HOUR 2135 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 12 DAY 21 YEAR 1911	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY 12c. KIND OF BUSINESS OR INDUSTRY OIL - HEAT ASSOC. OF MD.	
14. FATHER'S NAME FIRST MIDDLE LAST ULYSSES S.G. BERTOLET		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA BLANK		13c. STREET ADDRESS / ZIP CODE 4718 DARTFORD AVE. Balto, CITY. 21229	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-12-1113		17. INFORMANT ADDRESS DOROTHY BERTOLET SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LUNG CANCER - METASTATIC, SQUAMOUS DUE TO, OR AS A CONSEQUENCE OF (b) DEEP VENOUS THROMBOSIS. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/24 1987 to 8/6 1987, that (I) (we) last saw the deceased alive on 8/6 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Latha K Pillai MD				22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PILLAI, LATHA				22e. ADDRESS ST AGNES HOSPITAL, BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 8/10/87		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK MAUSOLEUM	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			
25a. DATE REC'D BY REGISTRAR AUG 07 1987				25b. REGISTRAR'S SIGNATURE Julia Denson-Rubens	

MEDICAL CERTIFICATION

085104 WNC 10 01

AUG 7 1961

063630 AUG 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 22490

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM H. BETHEA			2a. DATE OF DEATH MONTH DAY YEAR 8 11 87		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 02 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED WELDER		12b. KIND OF BUSINESS OR INDUSTRY BETH STEEL
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. BETHEA, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSA BLUE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-03-6454		17. INFORMANT BALTIMORE, MARYLAND ELSIE M. BETHEA 2349 EUTAW PL. APT. #2 21217	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac arrhythmia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

multiple myeloma

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Walter Koppre		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE/SIGNED 8/17/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8/15/1987	23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS INC.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR NAME NUTTER FUNERAL HOMES, INC.		25a. DATE REC'D. BY REGISTRAR AUG 21 1987	25b. REGISTRAR'S SIGNATURE J. Davidson-Randall
2501 GWYNNS FALLS PKWY, BALTIMORE, MD. 21216			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 may be retained by the funeral director. Page 4 may be retained by the funeral director. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

062431 AUG 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22491

REG.-NO

2. DECEASED NAME (TYPE OR PRINT) Dorothy V. Biebl			2a. DATE OF DEATH MONTH DAY August 7, 1987		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 30, 1899		6. AGE (IN YEARS (LAST BIRTHDAY)) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Mullican		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Parsley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-78-1591		17. INFORMANT ADDRESS Anthony V. Biebl 17 Broadship Road 21222	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>dehydration, hyperkalemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>urinary infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

S/P CVA, dementia, Hx MI

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Susan Denman</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Denman				22e. ADDRESS 5200 Eastern Ave Balt 21224			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-11-87	23c. NAME OF CEMETERY OR CREMATORY Moreland	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 2122			25. DATE REC'D. BY REGISTRAR AUG 11 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

005131 AUG 15 81



20% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22492

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Sarah Biorski			2a. DATE OF DEATH MONTH DAY YEAR 8/29/87		2b. HOUR 3:30 P.M.
3. SEX F female	4. RACE W hite	5. DATE OF BIRTH MONTH DAY YEAR 12 07 1908	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12. CITY OR TOWN OF DEATH Baltimore	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady	15. KIND OF BUSINESS OR INDUSTRY Retail		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balto 13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 6912 Brookmill Rd. 21215			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Levett	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Bloom	16. ADDRESS RUSSEAN APT. 1A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 212-01-5826	17. INFORMANT Mrs. Jean Pinerman- 3 Russean Court 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Congestive Heart Failure, terminal pulmonary hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 1987</u> to <u>Aug 29 1987</u> , that (I) (we) last saw the deceased alive on <u>Aug 29 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>F. Sarfarazi</u>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/29/87		
22d. PHYSICIAN'S NAME (TYPE OF PRINT) F. Sarfarazi, MD	22e. ADDRESS Sinai Hospital of Baltimore				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug 30/87	23c. NAME OF CEMETERY OR CREMATORY Bnai Isroel	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Sol. Levinson & Bros 6010 Reisterstown Rd		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 4 1987 <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

06488C 29-87

063735 AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22493
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Anna M. LAST: Blair			2a. DATE OF DEATH MONTH: 8 DAY: 23 YEAR: 87		2b. HOUR 8:45 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH: 4 DAY: 20 YEAR: 99		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST: Charles MIDDLE: CUMBERLAND LAST: CUMBERLAND			15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: HEALY LAST: HEALY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-24-5463		17. INFORMANT 21090 Mrs. Evelyn E. Blair, 205 Hance Ave., Linthicum, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>				22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.D.				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/27/1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cent.		23d. LOCATION CITY OR TOWN: Balto. A.A.Co. COUNTY: Maryland STATE:
24. FUNERAL DIRECTOR NAME: Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			25a. DATE REC'D. BY REGISTRAR AUG 25 1987		
			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

003132 102 50 81

102 50 81

102 50 81

062929 AUG 17 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22494
REG. NO.

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL Blumberg		2a DATE OF DEATH MONTH DAY YEAR 8-11-87		2b HOUR 3 A M
3 SEX Male	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 01 31 1914		6. AGE [IN YEARS LAST BIRTHDAY] 73 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levin Dale Nsg Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b KIND OF BUSINESS OR INDUSTRY WHOLESALE
13a STATE Md		13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST EDEL BLUMBERG		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH FREEDMAN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-ARMY 219-14-6099		17 INFORMANT MRS. BRONIA BLUMBERG APT. 411 3601 FORDS LA. BALTO., MD 21215
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE, DIABETES, CHRONIC OSTEOMYELITIS OF RT. HEEL				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (this hospital) attended the deceased from 8/7 19 87 , to 8/11 19 87 , that (we) lost saw the deceased alive on 8/11 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.				
22b SIGNATURE Estrelita O. Kw.		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 8/11/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KW, MD		22e ADDRESS LEVINDALE NURSING HOME - HOSPITAL		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE AUG. 12, 1987	23c NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO	23d LOCATION BALTIMORE COUNTY MARYLAND	
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		25a DATE REC'D. BY REGISTRAR AUG 14 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or cremation. The funeral director must be notified of any change in the burial or cremation date.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

4 3 2

085352 AUG 12 01

1. The first part of the report is a general description of the project. It includes the title, the objectives, and the scope of the work. The title is "A Study of the Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate." The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope of the work is limited to the reaction of hydrogen peroxide with potassium iodate in aqueous solution.

2. The second part of the report is a description of the experimental procedure. It includes the materials and apparatus used, the method of preparation of the solutions, and the method of measurement of the rate of reaction. The materials used are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus used is a titration flask, a burette, and a thermometer. The method of preparation of the solutions is described in detail. The method of measurement of the rate of reaction is described in detail.

AUG 14 1901

063792 AUG 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22495

1- STATE
REGISTER

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

Steve

Bobak

2a DATE OF DEATH MONTH DAY YEAR
8-21-87 10³⁵ AM

3. SEX

MALE

4 RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
2 18 09

6 AGE (IN YEARS LAST BIRTHDAY)

78 YRS.

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

IF UNDER 74 HRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Pennsylvania

7b CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Balto. City MD.

10 CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Joseph Richey House

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Carpenter

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE 13b COUNTY 13c CITY OR TOWN

Md. Anne Arundel Pasadena

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

7831 Elizabeth Rd. 21225

14 FATHER'S NAME

William

MIDDLE

LAST

Bobak

15 MOTHER'S MAIDEN NAME

Dorothy

MIDDLE

LAST

Kozar

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

206-16-4831

17 INFORMANT

Ada L. Bobak

ADDRESS

7831 Elizabeth Rd. Pas. Md. 21225

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) CARDIORESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(c) CANCER OF THE LUNG

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from JULY 18, 1987, to AUG. 21, 1987, that (I) (we) last saw the deceased alive on AUGUST 21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

J. M. Jannay

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c DATE SIGNED

8/21/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

L. M. JANNAY M.D.

22e ADDRESS

100 N. BROADWAY, BALTO. MD. 21231

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Entombment

23b DATE

8/24/1987

23c NAME OF CEMETERY OR CREMATORY

Cedar Hill

23d LOCATION CITY OR TOWN

Balto.

COUNTY

A.A.

STATE

Md.

24 FUNERAL DIRECTOR

NAME

George J. Gonce

ADDRESS

4001 Ritchie Hwy. Balto. Md. 21225

25a DATE REC'D. BY REGISTRAR

AUG 24 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Rodell

BP

DHMH - 16 50M 1/81
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified and a medical investigation must be conducted.

003105 WME 52 81

062327 AUG

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 1 9 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		2b. HOUR	
Clarence		W.		Boggs						8		4		19 87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	B	3 17 18		69 YRS.		MONTHS		DAYS		8		4		19 87		7:25P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
NJ		U.S.A.		WIDOWED		DIVORCED		Baltimore City								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		2421 Wellbridge Drive		RETIRED		N/A											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2421 WELLBRIDGE DR. 21239									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JAMES		BOGGS		UNKNOWN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		138-10-1265		FRANCES BOGGS		2421 WELLBRIDGE DR.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				CITY OR TOWN COUNTY STATE													
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held on death resulted from																	
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)										DATE SIGNED					
Mario F. Golle, Jr., M.D.		Assistant MEDICAL EXAMINER										8/5/87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										BALTO.MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
BURIAL		8/10/87		GARRISON FOREST		OWINGS MILLS,				MD							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE					
WM. C. MARCH F/H, INC.		1101 E. NORTH AVE.										AUG 7 1987					

07:84
25AM

BP
DHMH - 17
(VR A15 ME (5))

Julia D. B. B. B.

005355 AUG 11 61

AUG 11 1961

064471 SEP-28

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO 2 2 4 9 7

DECEASED NAME (TYPE OR PRINT) Thelma G. Bonner		2a DATE OF DEATH MONTH DAY YEAR August 29, 1987		2b HOUR 10:07pm
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 05-14-21		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Roscoe Mayer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iola Saunders		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 213-12-3064	17 INFORMANT ADDRESS Lerry Bonner 124 N. Carlton St.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (x) (this hospital) attended the deceased from July 25, 1987, to August 29, 1987, that (x) (we) last saw the deceased alive on August 29, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.				
22b SIGNATURE S. Chintresna		DEGREE MD.		22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. CHINTRESNA, MD.		22e ADDRESS c/o Maryland General Hospital		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 9-4-87	23c NAME OF CEMETERY OR CREMATORY Garnson Forest	23d LOCATION CITY OR TOWN STATE Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME Brown-Thompson F.H.		ADDRESS P.O. Box 4433		25a DATE REC'D. BY REGISTRAR SEP 1 - 1987
		25b REGISTRAR'S SIGNATURE Julia Sanders-Rodriguez		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

004471 SEP-58



3

SEP 1 1958



SEP 1 1958

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 4 9 8

FOR
1- STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Gregory

L.

Booker

2a. DATE OF DEATH
KNOWN ☒ ESTIMATED ☐
MONTH DAY YEAR
8/ 12/ 19 872b. HOUR
M
5:55
P M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR
8 5 56

6. AGE (IN YEARS)

(LAST BIRTHDAY)
31 YRS.

IF UNDER 1 YR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE

PRONOUNCED
DEAD

MONTH DAY YEAR

8/ 12/ 19 87

2d. HOUR

M
5:55
P M7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2848 Edgecomb Circle

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Unemployed

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2848 Oakford Ave. 21215

14. FATHER'S NAME

FIRST
Roosvelte

MIDDLE

LAST

Booker, Sr.

15. MOTHER'S MAIDEN NAME

FIRST
Inell

MIDDLE

McClendon

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

217-66-8757

17. INFORMANT

Inell Booker

ADDRESS

2848 Oakford Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Narcotic Intoxication

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR ~~XX~~ MONTH DAY YEAR
? P.M. 8/ 12/ 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

subject used drug

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

alley at

21f. LOCATION

2843 Edgecomb Circle, Balto. City, Md.

22a. I certify that I took charge of the remains described above, held an
death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒
Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinionACTUAL
SIGNATURE*Dennis F. Smyth, M.D.*

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED 8/13/87

EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

8/17/87

23c. NAME OF CEMETERY OR CREMATORY

Eastview Mem. Pk.

23d. LOCATION
(CITY OR TOWN)

Dundalk, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME
Wm C March F. H. WestADDRESS
4300 Wabash Ave

25a. DATE REC'D. BY REGISTRAR

AUG 17 1987

25b. REGISTRAR'S SIGNATURE

*Julia Davidson-Randall*TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

003020 AUG 18 81

062981 AUG 19 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 22499
REG. NO. 22499
22499
22499

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE BOOZE		2a. DATE OF DEATH MONTH DAY YEAR 8 15 87		2b. HOUR 6:38 AM	
3. SEX Female		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 11 12 16	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA New Bridge		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING			
13a. STREET ADDRESS / ZIP CODE 2710 RIGGS AVE 21216		13b. CITY OR TOWN BALTO. CITY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE BLACKWELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-32-7550		17. INFORMANT ADDRESS REBECCA HAMMOND 2315 N. MONROE ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock DUE TO, OR AS A CONSEQUENCE OF (c) Gangrene Bowels Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 8/14/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED acute abdomen		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/13/1987 to 8/15/1987, that (I) (we) last saw the deceased alive on 8/15/1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Z.N. LAHISI		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Z.N. LAHISI		22e. ADDRESS Liberty Medical Center Balto, Md 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-20-87		23c. NAME OF CEMETERY OR CREMATORY ARBUTHNOT CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		23e. DATE REC'D. BY REGISTRAR AUG 17 1987			
24. FUNERAL DIRECTOR NAME Joseph B. W. Hayes		ADDRESS 3111 Reisterstown Road		25a. DATE REC'D. BY REGISTRAR AUG 17 1987	
				25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

MEDICAL CERTIFICATION

99455

005281 AUG 19 85

063058 AUG 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG 400

2 2 5 0 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elodie Borgyon			2a. DATE OF DEATH MONTH DAY YEAR August 16, 1987		2b. HOUR AM PM 2:00 a
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12/25/03		6. AGE (IN YEARS LAST BIRTHDAY) YRS 83	7. IF UNDER 1 YEAR MONTHS DAYS 83
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp, Nurses Aide		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aide		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY --	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henri Dauwens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Euphrasie DeCook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 126-12-8328		17. INFORMANT ADDRESS Mr. Ivan Borgyon, Son same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: dementia - chronic					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/19/86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 611 S. Charles St. Baltimore, Md.	
22a. I certify that (I) (this hospital) attended the deceased from 8/16/87 to 8/16/87 , that (we) last saw the deceased alive on 8/16/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.R. Gladue		DEGREE MD		22c. DATE SIGNED 8/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Raymond Gladue		22e. ADDRESS 611 S. Charles St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/17/87	23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21216		ADDRESS 3331 Brehms Lane		25a. DATE REC'D. BY REGISTRAR 17 1987	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 has injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

060371

JUL 22 1987

Items, #2a, & 2c., 6-630, by Med. Ex., STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22501

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR																																															
FRANCIS Asbury BOSTON Jr.						20. DATE OF DEATH			7-17-87			12:40																																															
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR																																													
Male		Cau.		6-26-1917		70						7-17-87		12:40																																													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH																																															
Maryland				U.S.A.				WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore City																																															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																																															
Baltimore				2079 Druid Pk. Drive				Steelworker				Armco Stl.																																															
13a. STATE												13b. COUNTY												13c. CITY OR TOWN												13d. INSIDE CITY LIMITS?												13e. STREET ADDRESS											
Md.																								Baltimore												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												3608 Edgegreen Avenue											
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME																																															
Francis A. Boston Sr.												May Zellers																																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?												16b. SOCIAL SECURITY NO.												17. INFORMANT												ADDRESS																							
No												215-10-6946												Clark E. Boston												21090																							
																								200 E. Benton Ave																																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																															
PART 1 DEATH WAS CAUSED BY:												Arteriosclerotic cardiovascular disease																																															
IMMEDIATE CAUSE (a)												DUE TO, OR AS A CONSEQUENCE OF																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												(b)																																															
												DUE TO, OR AS A CONSEQUENCE OF																																															
												(c)																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																																											
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																																			
																								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR												21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																			
												P.M. 19																																															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)												21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																			
22a. I certify that I took charge of the remains described above, held in death resulted from:												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																															
death resulted from:												Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
ACTUAL SIGNATURE												TITLE (SPECIFY)												DATE SIGNED																																			
												M.D. Chief												7-18-87																																			
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS																																															
John E. Smialek, M.D.												111 Penn Street																																															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION CITY OR TOWN COUNTY STATE																							
Cremation												7-20-87												Security Process Inc. Baltimore												Md.																							
24. FUNERAL DIRECTOR NAME												ADDRESS												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE																							
Cremation Society of Md. Inc.												Md.												JUL 21 1987												John E. Smialek																							

DIVISION OF VITAL RECORDS, WESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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064303 SEP 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22502
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR BOWLWARE JR.			2a. DATE OF DEATH MONTH DAY YEAR AUG 24 1987		2b. HOUR 10³⁰ A.M.
3. SEX M	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12 15 25		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MED. TECH		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY BALTO. CITY		
13c. CITY OR TOWN BALTO. CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 3101 Windsor Ave 21216					
14. FATHER'S NAME FIRST MIDDLE LAST Arthur James Bowlware Sr.			15. MOTHER'S MIDDLE NAME FIRST MIDDLE LAST Cornelia Gladden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 245-26-5392		17. INFORMANT Kristal Bowlware	
16c. (IF YES, GIVE WAR OR DATES) WW II		ADDRESS 3101 Windsor Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA					1 month
DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL CA					4 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1					
19a. DATE OF OPERATION 6/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ESOPHAGEAL CA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 1, 1987 to AUGUST 24, 1987 , that (I) (we) lost saw the deceased alive on AUG 24, 1987 , and that in our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. AHEBENDT		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/24/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. AHEBENDT		22e. ADDRESS FSKEY HOSPITAL.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-31-87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MARYLAND
24. FUNERAL DIRECTOR William Brown		25. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE Julia...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

004308-101

062640 AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 5 0 3

1. DECEASED NAME (TYPE OR PRINT) Gertrude MARY Bowness			2a. DATE OF DEATH MONTH 8 DAY 8 YEAR 87		2b. HOUR 2:10 PM	
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 4, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. YEARS MONTHS DAYS HRS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Jenkins Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY HOUSE KEEPER	
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES LAPPE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE CRANE		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			17b. SOCIAL SECURITY NO. 215-22-4639		17c. INFORMANT MARJORIE BRENNAN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of uterine cervix, suspected 30yr DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) hypertension arteriosclerotic cardiovascular disease						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from 8-8-87 to 8-8-87, that (b) (we) last saw the deceased alive on 8-8-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.						
22b. SIGNATURE Laurence R. Gallagher, M.D.				22c. DATE SIGNED 8-8-87		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE R. GALLAGHER M.D.				23b. ADDRESS 900 CATON AVENUE, BALTIMORE, MD.		
23c. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL		23d. DATE 8/11/87		23e. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23f. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228				25a. DATE REC'D. BY REGISTRAR AUG 12 1987		25b. REGISTRAR'S SIGNATURE via Theodore Radner

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please register your papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of death.

BP

005040 and 1301

005040 and 1301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 22504

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louise E. Bowser</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>08-06-87</i>		2b. HOUR <i>7:00 A.M.</i>	
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>02-19-03</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>84</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY</i> MD.		
10. CITY OR TOWN OF DEATH <i>BALTO.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BON SECOURS Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>	13b. COUNTY <i>BALTO.</i>	13c. CITY OR TOWN <i>BALTO.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>4105 Fairfax Rd. 21216</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur Pritchett</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna ?</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-30-6455</i>		17. INFORMANT ADDRESS <i>Stanley Bowser 4105 Fairfax Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis & gangrene of legs</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD, cardiomyopathy, CHF</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Chronic dementia, pneumonia, malnutrition</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>C. Coulter MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/6/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Coulter</i>		22e. ADDRESS <i>Bon Secours Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>08-11-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Kings Memorial PK.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Brown/Thompson F.H.</i>		ADDRESS <i>P.O. Box 4433</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 10 1987</i>		
		25b. REGISTRAR'S SIGNATURE <i>Julia Sanders-Randall</i>				

BP _____

02520 AUG 11 85

AUG 10 1985

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8722505

1 - FOR
STATE
REGISTRAR

REG. NO.

063926

DECEASED NAME Baby Boy Charles Boyer Jr		FIRST MIDDLE LAST FIELDS		2a. DATE OF DEATH 8/12/87		2b. HOUR 7:53 PM	
3. SEX male	4. RACE Black	5. DATE OF BIRTH 8/12/87		6. AGE (IN YEARS LAST BIRTHDAY) 1 hr		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Newborn		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles BYER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA FIELDS		16. STREET ADDRESS / ZIP CODE 1612 McCulloh St - 21217			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Charles Boyer 1612 McCulloh St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest 2+</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe birth asphyxia 2+</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>overwhelming Sepsis (post surgery)</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6:34 PM 8/12/87 to 7:52 PM 8/12/87, that (I) (we) last saw the deceased alive on 8/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Afshaneh HESSAMFOR				22c. DATE SIGNED 8/12/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) AFSHANEH HESSAMFOR	
22e. ADDRESS University of Maryland Hospital				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/20/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, A.A.C. Md.	
24. FUNERAL DIRECTOR NAME Charles A. Rice ADDRESS RSPA 1300 Eutaw Pl,				25a. DATE REC'D BY REGISTRAR AUG 26 1987			

003050 W02 52 01



064376 SEP 1987

FOR
THE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 5 0 6

1. DECEASED NAME (TYPE OR PRINT)			FIRST Gilbert			MIDDLE Bradford			LAST Bradford			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 24 19 87			2b. HOUR M 24								
3. SEX M			4. RACE B2			5. DATE OF BIRTH MONTH DAY YEAR 6 20 37			6. AGE (IN YEARS) (LAST BIRTHDAY) 50 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. MONTHS DAYS HOURS MIN			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 24 19 87			2d. HOUR P.M. 5:45		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland						7b. CITIZEN OF WHAT COUNTRY? USA						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2043 Hollins St.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed						12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland												13b. COUNTY		13c. CITY OR TOWN Balto. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2043 Hollin St					
14. FATHER'S NAME FIRST MIDDLE LAST Malcolm Bradford						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Franklin																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) May-sept 1957 216-32-0179						17. INFORMANT ADDRESS Gloria Bradford 253 Robert St											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. <u>Diabetes mellitus</u>																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Dennis F. Smyth</u>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 8-25-87					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.												ADDRESS 111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (ENTRY) Burial						23b. DATE 8-28-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet						23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS Mills MD									
24. FUNERAL DIRECTOR NAME Wm. C. Brown												ADDRESS 1206 W. North Ave						25a. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

004040 209-108

MAKING

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22507

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DR. CATHY POPE SMITH BRAGG
2a. DATE OF DEATH MONTH DAY YEAR 8/27/87
2b. HOUR 11:58p.m.

3. SEX FEMALE 4. RACE B 5. DATE OF BIRTH MONTH DAY YEAR 4/5/33
6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MOBILE, ALANTA 7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.

10. CITY OR TOWN OF DEATH BALTO. 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1101 ST. PAUL STREET
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY 13c. CITY OR TOWN BALTO. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE 1101 ST. PAUL STREET 21202

14. FATHER'S NAME FIRST MIDDLE LAST WALTER C. POPE
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE POPE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) N/A
16b. SOCIAL SECURITY NO. 343-26-1352
17. INFORMANT ADDRESS DR. RICHARD BRAGG 1101 ST. PAUL ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that (if (this hospital) attended the deceased from Aug 1986 to Aug 1987, that (we) last saw the deceased alive on Aug 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (them) (did) (and) not prior to the body after death.

22a. SIGNATURE 22b. DEGREE M.D. 22c. DATE SIGNED 8/31/87
22d. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22e. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. ABELOFF 22f. ADDRESS Johns Hopkins Oncology Center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 8/31/87 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST
23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILL, MD.

24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT & SON 4600 LIBERTY HGTS.
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 01 1987 John Davidson-Randall

MEDICAL CERTIFICATION

2

1

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

064609 SEP-20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

084608 SEP-58

SEP 01 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove page 3 and 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other fact that may be pertinent, the medical examiner must be notified or contacted.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22508

1. DECEASED NAME (FIRST MIDDLE LAST) STERLING M. BRANDON		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 5, 1987		2b. HOUR 7:00PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6 9 25	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL H. BRANDON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERGIE WADE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-76-8290		17. INFORMANT ADDRESS LORRAINE BRANDON 2019 McELDERRY STREET 21205	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Middle Cerebral artery occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>3 weeks</u> <u>42 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Osteomyelitis of sacrum</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>8/25/87</u> , 19 <u>87</u> , to <u>8/5/87</u> , 19 <u>87</u> , that (I) <u>we</u> lost <u>saw</u> the deceased alive on <u>8/5/87</u> , 19 <u>87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> did (did not) view the body after death.					
22b. SIGNATURE <u>Anthony J. Bleyer, MD</u>				22c. DATE SIGNED <u>8/5/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Anthony J. Bleyer, MD</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE <u>8/12/87</u>		23c. NAME OF CEMETERY OR CREMATORY BALTO. CEMETERY	
23d. LOCATION CITY OR TOWN BALTO.		23e. COUNTY BALTO.		23f. STATE MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE				25. DATE REC'D. BY REGISTRAR <u>AUG 11 1987</u>	
25b. REGISTRAR'S SIGNATURE					

065612 AUG 13 81

065612 AUG 13 81

063791 AUG 26 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 22509

DECEASED NAME FIRST MIDDLE LAST
Thomas Robert Brannon2a DATE OF DEATH MONTH DAY YEAR HOUR
August 19, 1987 5:20 a.m.3 SEX Male 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR
11 24 15

6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

10 CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) First Mate 12b KIND OF BUSINESS OR INDUSTRY Merchant Marine

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY 13c CITY OR TOWN Balto. 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE 918 Lombard Street 21202

14 FATHER'S NAME FIRST MIDDLE LAST John Brannon 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie White

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b SOCIAL SECURITY NO 219 07 0813 17 INFORMANT ADDRESS Raymond Ferrell 3713 3rd Street Balto Md 21225

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF
(c).

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that ☒ (this hospital) attended the deceased from August 17, 19 87, to August 19, 19 87, that ☒ (we) last saw the deceased alive on August 19, 19 87, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.

22b SIGNATURE 22c. DATE SIGNED 8/19/87

22d PHYSICIAN'S NAME (TYPE OR PRINT) Samir Shabshab, M.D. 22e ADDRESS c/o Maryland General Hospital

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 8/21/87 23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park 23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.

24 FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hwy Balto. Md. 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE AUG 24 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows only one cause of death, the medical examiner must be notified at once.

083781 AUG 28 81

202

2001-1-1000

12/1/10

12/2/10

064383 SEP-1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22510

1. DECEASED NAME (TYPE OR PRINT) BRASHEARS, JOHN M.			2a. DATE OF DEATH MONTH DAY YEAR 08-23-87			2b. HOUR 6:55AM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR MARCH 10, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOCK RAVEN VETERANS HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRICKLAYER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2626 McELDERY ST. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH K. BRASHEARS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KOLB			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII			
16b. SOCIAL SECURITY NO. 216-18-6193			17. INFORMANT DOLORES BRASHEARS			17. ADDRESS 1503 UPSHIRE RD 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated lung carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Tobacco abuse DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/21/87 , 19 87 , to 8/24 , 19 87 , that (I) (we) lost saw the deceased alive on 8/24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B Schamberger MD						DEGREE PROFESSOR		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B Schamberger				22e. ADDRESS 3900 Lock Raven Blvd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE AUG. 28, 1987		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME HARTLEY MILLER				ADDRESS 7527 HARTFORD Rd		25a. DATE RECEIVED BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

064355 SEP 1 1987

Item 5, 6631 9-3-87 cw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC NO. 511

1- STATE REGISTRAR FOR DECEASED NAME (TYPE OR PRINT)		FIRST Henry		MIDDLE A.		LAST Braunschweiger		2a. DATE KNOWN OF DEATH ESTABLISHED MONTH DAY YEAR 8-28-1987		2b. HOUR M 7:57A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-17-1946		6. AGE (IN YEARS) LAST BIRTHDAY 41 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-28-1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Senior Credit Rep.		12b. KIND OF BUSINESS OR INDUSTRY Exxon Oil			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1608 Evergreen Dr. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST George E. Braunschweiger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen J. Rabenaw				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 271-46-0192				17. INFORMANT Kathleen J. Myers				ADDRESS 1608 Evergreen Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Chronic alcoholism</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 8-28-87			
EXAMINER'S NAME (TYPE OR PRINT) charles P. Kokes, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-1-87		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk				ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D BY REGISTRAR AUG 31 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 111.2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMM - 17
(VR A15 ME (5))

064322 SEP-191

AUG 31 1911

63217 AUG 20 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22512
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN T. BRAXTON			2a. DATE OF DEATH MONTH DAY YEAR 08 15 87		2b. HOUR 6:50 P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 10 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4709 Park Heights Ave 21215
14. FATHER'S NAME FIRST MIDDLE LAST Milton A. Braxton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gussie Braxton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-03-0105		17. INFORMANT Clifton Braxton ADDRESS 4709 Park Heights	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (b). <u>CEREBRAL VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF <u>Senile Dementia</u> (c). <u>Senile Dementia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 0/10 87 8/15 87	
22a. I certify that (I) (this hospital) attended the deceased from <u>08/15 87</u> to <u>8/15 87</u> , that (I) (we) last saw the deceased alive on <u>08/15 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kuang-yen Huang		DEGREE M.D.		22c. DATE SIGNED 08/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG		22e. ADDRESS BON SECOURS Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/20/87	23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West		ADDRESS 4300 Wabash Avenue		25a. REGD. OR REGD. PAR. 25b. REGISTRAR SIGNATURE AUG 19 1987 Julia Barber-Rudolph	

MEDICAL CERTIFICATION

99

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

03515 AUG 30 91

WILLIAM WILSON

1911

WILLIAM WILSON

WILLIAM WILSON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 5 1 3
2 2 5 1 3
REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

MILDRED KATHLEEN BRAZIL
MILDRED KATHLEEN BRAZIL

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
8 18 87 325 PM

3. SEX
FEMALE

4. RACE
WHITE

5. DATE OF BIRTH MONTH DAY YEAR
12 31 23

6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS.
63 YRS MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD.

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH
BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY HOSPITAL

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK

12b. KIND OF BUSINESS OR INDUSTRY
FRANK'S NURSERY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

Balto.

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

9015 TAMMY RD. 21236

14. FATHER'S NAME

FIRST
GEORGE

MIDDLE

LAST

GRAY

15. MOTHER'S MAIDEN NAME

FIRST
BEULAH

MIDDLE

LAST

UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO

16b. SOCIAL SECURITY NO.
217-12-7320

17. INFORMANT ADDRESS
JOHN BRAZIL (HUSBAND) SAME ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b)

PULMONARY METASTASIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

RENAL CANCER

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (I) (this hospital) attended the deceased from JUNE 18 19 86 to AUGUST 27 19 87, that (I) (we) lost saw the deceased alive on above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE

Flavio Kruter

DEGREE

ATTENDING
PHYSICIAN ☐

MEDICAL
DIRECTOR ☐

STAFF
PHYSICIAN ☒

22c. DATE SIGNED

8/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

FLAVIO KRUTER

22e. ADDRESS

22 South Greene St

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION

23b. DATE

8/21/87

23c. NAME OF CEMETERY OR CREMATORY

SECURITY PROCESS

23d. LOCATION

CITY OR TOWN

BALTIMORE

COUNTY

STATE

MD.

24. FUNERAL HOME, INC.
9705 Belair Rd., Balto. Md. 21236

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

AUG 21 1987

Julia Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Page 2 and 3 should be kept with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

03203 AUG 54 04

33213

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1000 1000 1000

1000 1000 1000

AUG 31 1987

062797 AUG 14 87

Items, 18a. & 22a., 6-631, by Med. Exam. STATE OF MARYLAND
FOR DATE 9/3/87, Gbj.
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH22514
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR			
WILLIAM M. BRINKLEY JR.						8-6-87			19			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE		BLACK		11 30 65		21 YRS.		MONTHS DAYS		HOURS MIN.		8-6-87		19 6:47a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
MD				USA								Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				1706 E. Fayette Street				UNKNOWN							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD						BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1706 E. FAYETTE STREET 21231					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)							
WILLIAM M. BRINKLEY SR.				IRMA BATSON				NO							
16b. SOCIAL SECURITY NO.				17. INFORMANT				16c. ADDRESS							
215-86-2668				IRMA COOK				2518 E. JEFFERSON STREET							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asthma</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 8-6-87				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL				8/14/87		BALTIMORE CEMETERY				BALTO. MD					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
WM. C. MARCH F/H				1101 E. NORTH AVENUE				AUG 13 1987 <u>Julia Denton-Rodner</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5-FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP 716
DHMH - 17
(VR A15 ME (5))

005103 AUG 14 84

AUG 13 1984

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RETURN TO MEDICAL EXAMINER. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESSION STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FIG. 2C

DECEASED NAME (TYPE OR PRINT)		FIRST NAKIA		MIDDLE BRITTINGHAM		LAST		7a. DATE KNOWN OF DEATH 8-10-87 ⁹		MONTH DAY YEAR		7b. HOUR			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH 3 23 87		6. AGE (IN YEARS) 4 18		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 8-10-87 ⁹ 9A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO, MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 441 E. Lanvale Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 441 E. LANVALE STREET					
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BRITTINGHAM						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RENEE CHANCE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT RENEE CHANCE				ADDRESS 441 E. LANVALE ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Margarta A. Korell</u>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 8-10-87			
EXAMINER'S NAME (TYPE OR PRINT) Margarta A. Korell, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/14/87		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE ANN ARUNDEL CO. MD					
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H						ADDRESS 1101 E. NORTH AVENUE		25a. DATE REC'D. BY REGISTRAR AUG 13 1987							

095803 MAR 14 83



095803 MAR 14 83

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22510

1- FOR
STATE
REGISTRAR

Bessie

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Brown			2a. DATE OF DEATH MONTH DAY YEAR 08 06 87			2b. HOUR 9 P.M.	
3. SEX F		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 07 05 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VINTA HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George McNeil		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie McNeil		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 241-24-9127	
16c. INFORMANT Jesse Brown		16d. ADDRESS 5406 Crismer		17. INFORMANT Jesse Brown		17b. ADDRESS 5406 Crismer	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 19 87, that (I) (we) last saw the deceased alive on 8/4/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Milan Winter				22c. DATE SIGNED 08/07/87		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MILAN WINTER				22f. ADDRESS 2435 West Belvidere Ave; Balto			
23a. BURIAL, CREMATION, REMOVAL (BY)		23b. DATE 8-10-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.	
24. FUNERAL DIRECTOR NAME James A. Morton & Sons				24b. ADDRESS 1701 Laurens		25. DATE REC'D. BY REGISTRAR AUG 11 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

002288 AUG 13 87

2011

8

W10

PROSTATE TUMOR

10/10/87

Prostate Tumor
Biopsy Specimen

10/10/87

PROSTATE TUMOR

10/10/87

REG NO. 2517

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		7b. HOUR									
Betty		Jean		Keys,		Brown		8/		11/		19		87													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		PRONOUNCED		DEAD		7d. HOUR									
Female		Black		8/11/52		34 YRS.		MONTHS		DAYS		HOURS		MIN		8/ 13/ 19 87		7:14									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				NEVER MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH											
N.C.				USA				WIDOWED				DIVORCED				Baltimore City,											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK				12b. KIND OF BUSINESS															
Baltimore				5000 Blk. Denview Way				FOR MOST OF WORKING LIFE)				OR INDUSTRY															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS											
Md.								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1424 Linwood Ave. 21213											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT											
FIRST				MIDDLE				LAST				FIRST				MIDDLE				LAST							
Earl				Keys				Frances				Keys				NO				218-62-5569				Frances Keys 2138 Mt. Royal Ter. 21217			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				PART 1 DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
								Strangulation																			
								Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)															
												DUE TO, OR AS A CONSEQUENCE OF															
												(c)															
												PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
				HOUR A.M. MONTH DAY YEAR																							
				? P.M. 8/ ? 19 87				subject strangled																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE							
				wooded area				5000 Blk. Denview Way, Balto. City, Md.																			
22a. I certify that I took charge of the remains described above, held an				Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																							
death resulted from:				Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				SIGNED															
Dennis F. Smyth, M.D.				Assistant				8/13/87																			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY				STATE							
Burial				8/17/87				Cedar Hill Cem.				Brooklyn A.A.				Md.											
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																			
Chas. A. Rice FSPA 1300 Eutaw Place				AUG 19 1987				Julia S. Sander-Randall																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL—TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PENSION STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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BP_____

DHMH - 17

(VR A15 ME (5))

DHMH - 17
VR A15 ME (5))

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UNION MADE IN U.S.A.



063807

AUG 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register and return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
BURNELL		BROWN		AUGUST 20, 1987		5:35p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		BLACK		MONTH DAY YEAR		75 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VA.		U.S.A.				BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		MARYLAND GENERAL HOSPITAL		DAY WORK		N/A			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1102 DRUID HILL AVE. APT 1113 21201	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
RICHARD		ANNIE		NO		213-34-8755		JOSEPH BROWN 9200 CHATTENHAM AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		CARDIAC ARREST		METASTATIC CARCINOMA OF THE COLON				5 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		METASTATIC COLONIC CARCINOMA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from		AUGUST 9, 1987		to		AUGUST 20, 1987		that (we) last saw the deceased alive on	
		AUGUST 20, 1987						and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
						8-21-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Fadi Matar, M.D.		c/o MARYLAND GENERAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		8/24/87		KING MEM. PARK		RANDALLSTOWN		MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WM. C. MARCH 1101 E. NORTH AVENUE				AUG 24 1987					

BP

063807 AUG 28 81

AUG 28 81

062725 AUG 14 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22519
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROL LYNNE BROWN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10. 1987		2b. HOUR 8:05A M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-7-1944		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTH PLACE (STATE OR FOREIGN) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 70 W. Green St. 21157			
14. FATHER'S NAME FIRST MIDDLE LAST Evan Harold Crumbacker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Grace Naomi Miller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-42-9433		17. INFORMANT James B. Brown		ADDRESS Same as # 13	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>bleet crisis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic myelogenous leukemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>4 yrs</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/22</u> , 19 <u>82</u> , to <u>8/10</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Sidney Adler MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/10/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY ADLER MD						22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-13-87		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Carroll Md.				
24. FUNERAL DIRECTOR NAME Thomas J. Fletcher & Son						25a. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE Julia Barlow-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

BP

085752 KOC 14 05

062081 AUG - 8 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22520
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				M
ELEASE		J.	BROWN	8 2 87				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 24 HRS		
FEMALE	BLACK	MONTH DAY YEAR 5 2 10		77 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
FLORIDA	USA			BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTO.	1413 EAST BROADWAY		UNEMPLOYED DISABLED		N/A			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MD		BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1413 N. BROADWAY 21213				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST ANDREW		FIRST MIDDLE LAST LIZZIE DUKES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO		249-68-8417		PEARLEASE WILLIAMS 1413 N. BROADWAY				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Heart attack.</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Failure</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus.</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR P.M. 8 2 1987		No injury				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE				
				April 17, 1978 to 8-2-87				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-24-87</u> to <u>8-2-87</u> , that (I) (we) last saw the deceased alive on <u>6-24-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
<u>Aldo Paz</u>		MD						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Aldo Paz. MD		1000 Eager St. Balto Md 21202						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		8/8/87		ST. JOHN CEMETERY		MANNING COUNTY STATE		
24. FUNERAL DIRECTOR		25. DATE RECD. BY REGISTRAR		25. REGISTRAR'S SIGNATURE				
NAME		ADDRESS						
WM. C. MARCH F/H, INC.		1101 E. NORTH AVE.		AUG 05 1987 <u>Julia Anderson-Rudolph</u>				

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1805081 AUG-287

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22521

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR
		James D. Brown					<input checked="" type="checkbox"/>		8	25	19 87	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
Male	Black	3/6/61	26 YRS.			8 25 19 87					2:50 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Washington D.C.		USA				Baltimore City				MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore		University Hospital (STU)		Truck Driver								
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS						
Md.		Baltimore				7107 Rudisill Ct. (07)						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Charles Brown		Lucille Brown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
NO		218-98-1699		Lucille Brown 4124 Potter St. (27) Cheryl Mitchell 1107 Rudisill Ct. (07)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 11:10M. 8 24 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Motorcyclist in collision with auto						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Liberty Rd Patterson Ave. Baltimore, Maryland								
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		8/30/87		Elam Baptist Ch. Cem.		Charles City Virginia						
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE								
Chas. A. Rice FSPA 1300 Eutaw Pl.		AUG 31 1987		Julia Sanders-Randall								


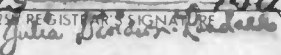
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DHMH - 17
(VR A15 ME (5))

062008 AUG

FOR
JUDGE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 2 5 2 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JETHRO C. BROWN			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 4 19 87		2b. HOUR M 6:49 A
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Jan. 17-08 79 YRS.	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 79	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 4 19 87	7d. HOUR M 6:49 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2625 E. Preston St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Clerk	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvester Hilliard		16. SOCIAL SECURITY NO. 217-01-0349	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-01-0349		17. INFORMANT Mattie Brown	
17. ADDRESS 2625 E. Preston St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 8-4-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-8-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park Arbutus	
24. FUNERAL DIRECTOR NAME Randolph J. Collick		ADDRESS 2431 E. Oliver St.		25a. DATE RECEIVED BY REGISTRAR AUG 06 1987	
25b. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

025008 KNC-981

W.C. J.S.F.
W.C. J.S.F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item 5, 13e, 15 Film G630 SB		STATE OF MARYLAND	
FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
11-87 per FH		CERTIFICATE OF DEATH	
062082 AUG 08		87 7 22523	
DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH	
FIRST MIDDLE LAST		MONTH DAY YEAR	
JOHN C. BROWN JR.		08-1-87	
2b HOUR		5:55AM	
3 SEX		4 RACE	
MALE		BLACK	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR		YRS MONTHS DAYS HOURS MIN.	
0-1-87		70	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	
S.C.		U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
BALTIMORE		LIBERTY MEDICAL CENTER	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Unemployed		N/A	
13a STATE		13b COUNTY	
MD.		BALTO.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
John Brown Sr.		Hattie Johnson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
NO		252-32-796	
17. INFORMANT		ADDRESS	
Gertrude Johnson		1500 Madison Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
CARDIO-PULMONARY ARREST			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
S/P Radical Neck Surgery			
DUE TO, OR AS A CONSEQUENCE OF			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (b) (c)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7:30 19 87 to 8-1 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
8/1/87		ANTHONY C. DIKE, MD	
22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Liberty Medical Center Baltimore		Julia Gordon-Randall	
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE	
Burial		8-6-87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
King Mem. PK.		Randallstown MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
WM. C. MARCH F/H		AUG 05 1987	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
1101 E. North Ave.		Julia Gordon-Randall	

BP

185085 AUG-88

185085
AUG-88

BLACK

WHITE

20% COLSON-ETHEL

185085
AUG-88



185085 AUG-88

061863 AUG 7 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22524
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Melvin</u> MIDDLE <u>Leonard</u> LAST <u>Brown</u> <u>Melvin Brown</u>				2a. DATE OF DEATH MONTH <u>8</u> DAY <u>4</u> YEAR <u>87</u> 2b. HOUR <u>2:00</u> AM	
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>13</u> YEAR <u>1935</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>52</u> YRS. IF UNDER 1 YEAR: MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS: HOURS <u></u> MIN <u></u>	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hospital</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>	
14. FATHER'S NAME FIRST <u>Abraham</u> MIDDLE <u></u> LAST <u>Brown</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Daisy</u> MIDDLE <u></u> LAST <u>Herring</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>N/A</u>		16b. SOCIAL SECURITY NO. <u>216-30-6954</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
17. INFORMANT <u>Mrs. Audrey Brown Same as #13e</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>312 N. Franklinton Rd.</u> <u>21223</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Advanced Metastatic Lung Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 7b, PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1987</u> to <u>August 4, 1987</u> , that (I) (we) last saw the deceased alive on <u>Aug 4, 1987</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>John A. Tygart</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/4/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John A. Tygart</u>		22e. ADDRESS <u>c/o S. Baltimore General Hospital.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>8-4-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonsville Balto, Md.</u>		23e. DATE REC'D. BY REGISTRAR <u>AUG 5 1987</u>		23f. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Cremation Society of Md. Inc. Balto. Md.</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

The first of the three
 items is a letter from
 the State Department
 dated August 1, 1958.
 It is addressed to the
 Director of the Federal
 Bureau of Investigation
 and is signed by the
 Assistant Secretary
 for International
 Affairs.

The second item is a
 letter from the
 Department of State
 dated August 1, 1958.
 It is addressed to the
 Director of the Federal
 Bureau of Investigation
 and is signed by the
 Assistant Secretary
 for International
 Affairs.

The third item is a
 letter from the
 Department of State
 dated August 1, 1958.
 It is addressed to the
 Director of the Federal
 Bureau of Investigation
 and is signed by the
 Assistant Secretary
 for International
 Affairs.

062881 AUG 17 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

22525
8:10:87 2:35A M

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL J BROWN, Sr.		7a. DATE OF DEATH MONTH DAY YEAR 8:10:87		7b. HOUR 2:35A M	
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 6 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Cn.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Ford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-8300		17. INFORMANT Ruth Cn. Brown 4117 Rockfield Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his) (hospital) attended the deceased from 7/22/87, 1987, to 8/10, 1987, that (I) (we) last saw the deceased alive on 8/10, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K DESAI		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K DESAI		22e. ADDRESS North Charles Hosp Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/15/87		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Md.		24. FUNERAL DIRECTOR Wm C March F/H West 4300 Wabash Ave.			
25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE Julia Dondor-Randall			

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top portion of the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other medically event, the medical examiner must be notified at once.

005881 AUG 12 61

22222

Handwritten notes and markings on lined paper, including a large 'X' and various illegible scribbles.

064377 SEP-1-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22526
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ROOSEVELT BROWN			2a. DATE OF DEATH MONTH DAY YEAR August 08 27 87		2b. HOUR 3:50pM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chester, S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md. MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 Mt Holly Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		
13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 300 Mt. Holly Street 21229					
14. FATHER'S NAME FIRST MIDDLE LAST Nmanuel Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 149-09-8702		17. INFORMANT ADDRESS Shirley M. Fisher 2335 Lauretta Ave. 21223	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis (D) Tetra + fibrile					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension - CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from June 1, 1984 to August 27, 1987 , that (I) (we) last saw the deceased alive on Aug 27, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death .					
22b. SIGNATURE Marshall W. Jones, Jr.		DEGREE MD		22c. DATE SIGNED 8/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marshall W. Jones, Jr.		22e. ADDRESS 844 On. Carey St. 21217			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 0902/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, A.A. Co., Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Marshall W. Jones, Jr. FH 4101 Edmondson Ave. 21229		25. DATE RECEIVED BY REGISTRAR AUG 31 1987			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

IMPORTANT: If item 24 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

084377 SEP-187

COTTON FIBER

Item #1 G 631 9/2/87 CW

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 22527

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
WILLIAM S. BROWN, JR.								08		15		87				9:55 P.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
M		B		MONTH DAY YEAR 3 06 38		49 YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD	
MD						CITY											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE		South Baltimore Gen Hosp.		Adminstrator													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
MD		A A		Glen Burnie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1516 BARRACK LA									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST WILLIAM S. BROWN, JR.		FIRST MIDDLE LAST CHRISTINA FRIDSON															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT													
No		214348698		Glen Burnie, Maryland													
				Mrs. Thelma Brown 1516 Barrack Lane 21061													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PANCREATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>87</u> , to <u>8/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Pravill Patel</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/15/87</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PRAVILL PATEL</u>						22e. ADDRESS <u>3001 S. HANOVER ST.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		8-20-87		Meadowridge Memorial Park		Baltimore				Maryland							
24. FUNERAL DIRECTOR NAME <u>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy</u>						25a. DATE REC'D. BY REGISTRAR <u>AUG 21 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Randall</u>									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and return them to the funeral director. Page 4 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

103051 AUG 52 01



064354 SEP 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22528
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
BENJAMIN						BRYAN JR.		AUGUST 26, 1987				4:55 ^M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Dec. 17, 1922				64 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
North East, Md.		U.S.A.						BALTIMORE CITY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL						Purchasing Man				Chemical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE			
Md.		Cecil		Elkton				YES		60 Cardinal Lane 21921			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
Benjamin Asbury Bryan		Mary Belle Creswell		yes		Korean		215-16-1201		Doris H. Bryan 60 Cardinal Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIC COMA</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF												3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												2 months	
DUE TO, OR AS A CONSEQUENCE OF												2 months	
(c) <u>HEMORRAGIC UREMIC SYNDROME</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
<u>Metastatic Carcinoma of Prostate</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
8/20/87		Insertion of graft for hemodialysis				YES							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 03</u> , 19 <u>87</u> , to <u>August 26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>August 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
<u>M. Shonk</u>		MD.						8/26/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
M SHONK		Johns Hopkins Hospital Wolfe St Baltimore Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		8-31-87		R. A. Ferris Crem.		West Chester Chester Pa.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS		AUG 31 1987				<u>John Darden</u>							
<u>See FUNERAL HOME, PA.</u>		<u>ELKTON, MD.</u>											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please make a copy of the original and send it to the State Dept. of Health and Mental Hygiene prior to burial cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

63181
AUG 19 87FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 2 5 2 9

1. DECEASED NAME (TYPE OR PRINT) George R. Bryant			7a. DATE OF DEATH MONTH DAY YEAR 8 4 87		7b. HOUR 11:45 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 21 26	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montana	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Vernon Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2831 Hampden Ave. 21211
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown		16b. SOCIAL SECURITY NO. 516-26-1855		17. INFORMANT ADDRESS MT. VERNON CARE CENTER-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>8/4/87</u> to <u>8/4/87</u> , that (I) (we) last saw the deceased alive on <u>8/4/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. C. Enriquez</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. ENRIQUEZ, MD		22e. ADDRESS 2435 W. BELVEDERE AVE 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-5-87		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 18 1987	
25b. REGISTRAR'S SIGNATURE <u>John Dindon-Pardone</u>					

3181 AUG 19 67

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, pages signed, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician should be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22530
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Brynes Dorothy Brynes DOROTHY</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>August 30 87</i>		2b. HOUR <i>9:22 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>01 27 1916</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE City MD</i>		10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NOT EMPLOYED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		13a. STREET ADDRESS / ZIP CODE <i>424 TRAPPE RD - 21222</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrew Ferguson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Magie Bouldins</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <i>no</i>	
16b. SOCIAL SECURITY NO. <i>220303501</i>		17. INFORMANT <i>KaySteigerwald</i>		ADDRESS <i>424 Trappe Road 21222</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIA ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1 SEPSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>UNKNOWN / known</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Chronic Renal failure, Diabetes</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/29 1987</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>7/29</i> 19 <i>87</i> to <i>8/30</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>7/29</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Padia Duna</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/30/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PADIA DUNA</i>		22e. ADDRESS <i>GOOD SAMARITAN HOSPITAL</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/2/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Memorial Park</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Connelly Funeral Home of Dundalk 21222</i>			
25a. DATE REC'D. BY REGISTRAR <i>SEP 1 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia T. ...</i>			

MEDICAL CERTIFICATION

106-332 018430

062410 AUG 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and checked.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22531

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1a. BASED NAME (TYPE OR PRINT)		2c. MONTH DAY YEAR		2d. MIN	
Dorothy		08 5 87		8 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		Feb. 28 1941	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
W. Va.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balt		Francis Scott Key		Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Balto.		Balto.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.	
Arthur J. Griffith		Roberta Lee Hurst		213-42-0370	
16b. DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. INFORMANT		ADDRESS	
no		Donald Buchholz		719 south 49th Street 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Brain death		240			
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) transventricular herniation		360	
		(c) subarachnoid hemorrhage		5 d	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/27 19 87 to 8/5 19 87 that (I) (we) lost saw the deceased alive on 8/5 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
L. M. A.				8/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
R. Lewis		Francis Scott Key			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8/7/87		Oak Lawn Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
NAME ADDRESS		CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE	
Connelly Funeral Home 300 Mace Ave. 21221		Baltimore Maryland		AUG 7 1987 Julia Benson-Randall	

7

063065 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 5 3 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
Amelia			Buckingham			8/ 6/ 1987			12:26 P M										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		24 HOUR					
Female		Cauc.		3-3-1912		75 yrs.		MONTHS		DAYS		8/ 6/ 1987		P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.				USA				Baltimore City				MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				3107 Milford Ave.				Unemployed				-							
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Md.				Baltimore				Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3107 Milford Avenue 21207			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST								FIRST MIDDLE LAST											
Wilbur Buckingham								Bertha Mercer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
no								567-07-2394				H. LaRue Parke 3136 Harford Road 21218							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART 1 DEATH WAS CAUSED BY: Hypertensive Cardiovascular Disease and Congestive Heart Failure																			
IMMEDIATE CAUSE (a) _____																			
DUE TO, OR AS A CONSEQUENCE OF _____																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. _____																			
(b) _____																			
DUE TO, OR AS A CONSEQUENCE OF _____																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
Cachexia																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held in death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Charles P. Kokes, M.D.				Assistant				8/7/87				MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Charles P. Kokes, M.D.				111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				8-13-87				Lorraine Park				Baltimore, Md.							
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Schimunek Funeral Home, Inc.				AUG 17 1987															
3331 Brehms Lane, Balto., Md. 21213																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

003002 AUG 18 81



AUG 17 81

062289 AUG

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22533

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DORIS M. BULLOCK			2a. DATE OF DEATH MONTH DAY YEAR 09 07 87			2b. HOUR 7:35A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 22 19		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD			
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN / HAMILTON		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HWF.		15. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3200 HAMILTON AVE # 21214	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE TRACESER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					
16b. SOCIAL SECURITY NO. 219-10-9483		17. INFORMANT ADDRESS Mrs. Deanna C. Smith 10 King Charles Circle							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 17</u> , 19 <u>87</u> , to <u>August 7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Corazon Vergara-Scares</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CORAZON VERGARA-SCARES		22e. ADDRESS 2947 ST. BAL ST. BALT. MD. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE <u>John B. Ruck</u>			

MEDICAL CERTIFICATION

065598 VNC 11 81

AUG 10 1981

062436 AUG 28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22534
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stanley W Burdette Sr			2a. DATE OF DEATH MONTH DAY YEAR 8 8 87		2b. HOUR 11:40p
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9 19 02		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Route Salesman-Hauswald		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George W.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bowman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-10-6499A		17. INFORMANT ADDRESS 1208 Leeds Terr.-Balto., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Previous Arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) 1) Pulmonary Embolism (S/P Pulmonary - Chronic Pulmonary)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 6/19/87 to 7/31/87 , that (1) (we) last saw the deceased alive on 7/31/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)					
22b. SIGNATURE John C. Healy		DEGREE MD		22c. DATE SIGNED 8/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Healy		22e. ADDRESS 1311 FRANKLIN Ave. Balto, Md 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Howard Md.		24. FUNERAL DIRECTOR G. Truman Schwab		25a. DATE REC'D. BY REGISTRAR AUG 11 1987	
25b. REGISTRAR'S SIGNATURE William R. Rader		26. REGISTRAR'S SIGNATURE William R. Rader			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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064409 SEP-187

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 5 3 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETSY BURGESS			2a. DATE OF DEATH MONTH DAY YEAR 08 21 87		2b. HOUR 5:18 M
3. SEX F	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 10 18 22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY -----00---
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALT		
13c. CITY OR TOWN BALT			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Carter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) -0-0-0-0-b-		16b. SOCIAL SECURITY NO. 003-71-8956		17. INFORMANT DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA / SEPSIS - DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SPINO-CEREBELLAR DEGENERATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/5 , 19 87 , to 8/21 , 19 87 , that (I) (we) last saw the deceased alive on 8/21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chapman		DEGREE MD		22c. DATE SIGNED 8/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VOR PERIAN		22e. ADDRESS Sinai Hosp. of BALT.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 26, 87		23c. NAME OF CEMETERY OR CREMATORY Md Nat Mem Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md		23e. DATE REC'D BY REGISTRAR AUG 31 1987			
24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave.		25a. DATE REC'D BY REGISTRAR AUG 31 1987			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Kendall					

BP

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STANDARD FORM NO. 64
MAY 1962 EDITION
GSA FPMR (41 CFR) 101-11.6

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062939 AUG 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the official causing the death should be noted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 22530				
1. DECEASED NAME (TYPE OR PRINT) Evelyn Burgess				2a. DATE OF DEATH MONTH DAY YEAR 8/12/87				2b. HOUR 7¹⁰ PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 3, 1895		6. AGE (IN YEARS (LAST BIRTHDAY)) 91		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason F. Lord Building				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
13a. VISUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Charles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emaline Miller		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
17. STREET ADDRESS / ZIP CODE 2000 O'Dell Avenue 21237		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19. SOCIAL SECURITY NO. 214-74-6916		20. INFORMANT ADDRESS Mr. J. Wesley Jenkins Towson, MD 21204		
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) chronic pseudo colonic obstruction DUE TO, OR AS A CONSEQUENCE OF (c) year.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia - severe								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/12/87 , 19 1987 , to 8/12/87 , 19 1987 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 7/12/87 , 19 1987 , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.								
22b. SIGNATURE J. R. Burton DEGREE				22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8/13/87		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. Burton				22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/15/1987		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland ADDRESS AUG 14 1987				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John A. Davidson		

065330 000 12 83



NOTICE
FOR
RECORD

NOTICE
FOR
RECORD

058438 JUL - 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

22537

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond Edwin BURKENTINE			2a DATE OF DEATH MONTH DAY YEAR June 30, 1987		2b HOUR P M 5:30 P
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 17, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS 69
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor (Ret)		12b KIND OF BUSINESS OR INDUSTRY C&P Telephone
13a STATE Maryland	13b COUNTY A A Co.	13c CITY OR TOWN Linthicum Hgts	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 107 Twin Oaks Road 21090	
14 FATHER'S NAME FIRST MIDDLE LAST Paul R. Burkentine		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Campbell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) NA	17 INFORMANT (Wife) Hilda Burkentine		ADDRESS Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Asystole DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease + Probable DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION Recurrent atrial fibrillation and Congestive Heart Failure					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>87</u> , to <u>6/30</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on above (1) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dennis M. Smith MD		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 6/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS SMITH MD		22e ADDRESS 3455 Wilkens Avenue Baltimore, Md. 21229			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b DATE Jul 3, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A A Co. Md.		
24 FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland	25a DATE REC'D. BY REGISTRAR JUL 02 1987	25b REGISTRAR'S SIGNATURE Julia Tindon-Rudolph	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

REGISTER

20% COTTON FIBER



W. N. FAIR



100-100-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 5 3 8
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (PRINT NAME) FIRST MIDDLE LAST Pauline H. Burkins			2a. DATE OF DEATH MONTH DAY YEAR 8-16-87		2b. HOUR 3:40A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-4-1901		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Hamilton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3537 E. Northern Pkwy. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar L. Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Gardiner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 217-40-1935		17. INFORMANT ADDRESS Edgar S. Burkins, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CA rectorum / CHF										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 85 to August 16 19 87 , that (I) (we) lost saw the deceased alive on August 16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Corazon Soares			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-17-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Corazon Soares, M.D.			22e. ADDRESS 2947 St. Paul St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-20-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.					25a. DATE REC'D. BY REGISTRAR AUG 18 1987					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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AUG 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 13a,b,c,d,e, Film

 FOR STATE G631 per F.H.
 REGISTRAR 9-8-87 dw

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 5 3 9

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR			2b. HOUR		
Nathan			Burman			8-21 1987			M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
MALE		WHITE		APR. 15, 1914		73 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
POLAND				USA				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Baltimore				University Hospital				EXECUTIVE HOLLY POULTRY CO.			
13a. STATE OF RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13b. STATE MARYLAND 13c. PALM BEACH CO. 13d. BALTIMORE											
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. SOCIAL SECURITY NO.			
KADISH BURMAN				ZELDA SETTLER				212-09-2333A			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				17b. SOCIAL SECURITY NO.				17. INFORMANT			
NO				212-09-2333A				MRS. ROSE BURMAN APT. 213 7 SLADE AVE. BALTO., MD 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:22PM 8-21 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (STREET, FACTORY, FARM, ETC.) parking lot				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2500 Hollins Street, Baltimore City, MD			
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 8-22-87											
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
BURIAL				AUG. 23 1987				BETH ISAAC ADATH ISRAEL BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME				24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR			
SOL LEVINSON & BROS. INC.				6010 REISTERSTOWN RD. BALTO., MD 21215				AUG 25 1987			
								25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 5 4 0
REG. NO.

DECEASED NAME (TYPE OR PRINT) SIDNEY O. BURNETT, SR.			2a. DATE OF DEATH MONTH DAY YEAR 8 20 87		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 1 98		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2818 Riggs Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School System	12b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2818 Riggs Avenue 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Burnett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Craig			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-09-9483	17. INFORMANT ADDRESS Dr. Sidney O. Burnett, Sr 3210 W. Strathmore Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cod liver oil Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lymphocytic Leukemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> to <u>August 20 19 87</u> that (I) (we) last saw the deceased alive on <u>August 20 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (I) did not see the body after death.					
22b. SIGNATURE <u>RUBEN REIDERMAN</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDERMAN		22e. ADDRESS 7445 FURMAN BRANCH RD Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/23/87	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F. H. West		ADDRESS 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987	25b. REGISTRAR'S SIGNATURE John S. Rindler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 22541

1. DECEASED NAME (TYPE OR PRINT) CLIFFORD			2a. DATE OF DEATH MONTH DAY YEAR 8 9 87			2b. HOUR 12 30 PM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 13 38		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD				
12. CITY OR TOWN OF DEATH Balt City		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F. LOVEL N/H				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md.			16b. COUNTY Balto.		16c. CITY OR TOWN Middle River		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 13114 Cherwin Ave. 21220	
17. FATHER'S NAME FIRST MIDDLE LAST Clifford Burruss Sr.			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hildegarde Bens			19. ADDRESS Hildegarde Burruss 13114 Cherwin Ave. 21220				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			21. SOCIAL SECURITY NO. 216-34-0003			22. INFORMANT Hildegarde Burruss				
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Anoxic Encephalopathy									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
24a. DATE OF OPERATION			24b. CONDITION FOR WHICH OPERATION WAS PERFORMED				24c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 9 19 87		25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) 6-2		25d. LOCATION STREET CITY OR TOWN COUNTY STATE 4940 Eastern Ave Balto MD			
26a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		26c. LOCATION STREET CITY OR TOWN COUNTY STATE		26d. I certify that (1) this hospital attended the deceased from 8-9 19 87 to 8-9 19 87 , that (2) we lost sight of the deceased on 8-9 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not view the body after death.)			
27a. SIGNATURE Richard Bennett M.D.			27b. DEGREE M.D.				27c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27d. DATE SIGNED 8.10.87	
28a. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett M.D.			28b. ADDRESS 4940 Eastern Ave Balto MD							
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			29b. DATE 8/11/87		29c. NAME OF CEMETERY OR CREMATORY SecurityProcessInc.		29d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
30. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221			31. DATE REC'D. BY REGISTRAR AUG 11 1987		32. REGISTRAR'S SIGNATURE J. L. Tindall					

MEDICAL CERTIFICATION

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DAVIDSON

AUG 1 1983

Burton, Earl S.
063146 AUG 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22542

1. DECEASED NAME (TYPE OR PRINT) FIRST: EARL MIDDLE: S. LAST: BURTON			2a. DATE OF DEATH MONTH: 08 DAY: 15 YEAR: 87		2b. HOUR 5:45 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH: Oct. 10, 1912 DAY: 10 YEAR: 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____ IF UNDER 24 HRS. HOURS: _____ MIN.: _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown	12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST: John MIDDLE: Joseph LAST: Burton			15. MOTHER'S MAIDEN NAME FIRST: Margaret MIDDLE: _____ LAST: Hill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 235-10-3972		17. INFORMANT Oak Hill, W. Va. 25901 Tyree Funeral Home, 999 Jones Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADVANCED ADENOCARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEMOPTYSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. Belani				22c. DATE SIGNED 8/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDRA P. BELANI				22e. ADDRESS CHURCH HOSPITAL BALTIMORE MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 18, 1987	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Gdns.	23d. LOCATION CITY OR TOWN: Prosperity, Raleigh, W. Va. COUNTY: _____ STATE: _____	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25a. DATE REC'D. BY REGISTRAR AUG 18 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

061904 AUG -7-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22543

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE BUSH			2a. DATE OF DEATH MONTH DAY YEAR 8 3 87		2b. HOUR MIN. 1100 P
3. SEX F	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 5 5 02		6. AGE (IN YEARS (LAST BIRTHDAY)) 85	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 627 S Poca Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Carving		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 627 S Poca Street	
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE W BUSH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE W. Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N		16b. SOCIAL SECURITY NO. 220-05-8894		17. INFORMANT ADDRESS JOSEPH BUSH 627 S Poca St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Metastatic Ovarian Carcinoma. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 7/24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Young S Kim		DEGREE MD		22c. DATE SIGNED 8/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Young S Kim		22e. ADDRESS 22 Greene St. Balt MD 21201			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/8/87	23c. NAME OF CEMETERY OR CREMATORY St Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD 21225
24. FUNERAL DIRECTOR Wanda Lee Adams		ADDRESS 438 N. Colman		25a. DATE REC'D. BY REGISTRAR AUG 05 1987	25b. REGISTRAR'S SIGNATURE Julia...

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001204 THE-781

063151 AUG 9 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22544

1. DECEASED NAME (TYPE OR PRINT) Patrick William Patrick Butler			2a. DATE OF DEATH MONTH DAY YEAR HOUR 8-15-87 5:57AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-31-1893	6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1516 Lancaster St. 21231
14. FATHER'S NAME FIRST MIDDLE LAST Patrick J. Butler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria E. Donovan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-54-3053	17. INFORMANT ADDRESS Violet W. Butler 102 4th. Ave. Apt. 2 Glen Burnie		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PERFORATED CAECUM WITH COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) INFECTED DECUBITUS ULCER					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: PARKINSONS DISEASE (X)					
19a. DATE OF OPERATION 8-3-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED CAECUM		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-23- 19 87 to 8-14- 19 87 that (I) (we) last saw the deceased alive on 8-14- 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE James E. Mathew		DEGREE M.D.		22c. DATE SIGNED 8-15-87	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. MATHEW		23b. ADDRESS 5411 OLD FREDERICK RD, Catonsville 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-18-87	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 901 S. Conkling St.		25a. DATE REC'D. BY REGISTRAR AUG 18 1987	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

063121 AUG 13 81

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "received" and "date" are visible.]

063121 AUG 13 81

062889 AUG 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 REG. NO 2 25 45
2a. DATE OF DEATH MONTH DAY YEAR HOUR
08 12 87 3 AM

1. DECEASED NAME (TYPE OR PRINT) Edith HAZEL BYRON		2b. DATE OF DEATH MONTH DAY YEAR HOUR 08 12 87 3 AM	
3 SEX female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 22 97	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 90. YRS	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital + Medical Center	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Cavana	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Mills	17. INFORMANT ADDRESS Charles Hubbell, 4017 Hollins Ferry Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---	17. INFORMANT ADDRESS Charles Hubbell, 4017 Hollins Ferry Road	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>87</u> , to <u>8/12/</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>RUBEN REIDER MD</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER MD		22e. ADDRESS 7445 TURNAGE BRANCH RD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/14/87	23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Park	23d. LOCATION CITY OR TOWN COUNTY Sykesville Carroll Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR AUG 14 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if other traumatic event, the medical examiner must be notified or contacted.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

065888 AUG 12 81

065888 AUG 12 81

AUG 14 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22546
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE E. BYRON		2a. DATE OF DEATH MONTH DAY YEAR 8-19-87		2b. HOUR 11:30 P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 12 09		6. AGE (IN YEARS LAST BIRTHDAY) 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Saffran		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Cavey		13e. STREET ADDRESS / ZIP CODE 2720 Dillon Street, 21224	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-01-7463D		17. INFORMANT ADDRESS Charles E. Herbert, Sr., 1240 Pleasant Valley Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE WITH SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA / URINARY INFECTION. DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DIABETES MELLITUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-29-19-87 to 8-19-19-87 , that (I) (we) last saw the deceased alive on 8-19-19-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Amil N. Raiker		DEGREE L.M.C.		22c. DATE SIGNED 8-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMIL N. RAIKER		22e. ADDRESS 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987	
25b. REGISTRAR'S SIGNATURE John E. ...					

083103 AUG 22 81

16

100% COTTON

41866

062941 AUG 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22547
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST: William, MIDDLE: Henry, LAST: Calo, Sr.			2a DATE OF DEATH MONTH: 8, DAY: 13, YEAR: 87		2b HOUR 0245am						
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH: 11, DAY: 17, YEAR: 21		6 AGE [IN YEARS (LAST BIRTHDAY)] 65 YRS.		IF UNDER 1 YEAR MONTHS: , DAYS: , HOURS: , MIN.		IF UNDER 24 HRS. HOURS: , MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Charfer		12b KIND OF BUSINESS OR INDUSTRY Bakery			
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Arbutus		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS - ZIP CODE 1302 Poplar Ave. 21227			
14 FATHER'S NAME FIRST: John, MIDDLE: Calo, LAST: Calo				15 MOTHER'S MAIDEN NAME FIRST: Maria, MIDDLE: Lovell, LAST: Lovell							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WW II 216-12-2426		17 INFORMANT ADDRESS Dolores Calo 1302 Poplar Ave. 21227							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5min											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c Adenocarcinoma of esophagus											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (the hospital) attended the deceased from 3-12-87, 19, to 8/13/87, 19, that (I) (we) last saw the deceased alive on 8-6-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (we) (did not) view the body after death.											
22b SIGNATURE [Signature] 22c PHYSICIAN'S NAME (TYPE OR PRINT) Paul Gormley				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d DATE SIGNED 8/13/87			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 08/15/87		23c NAME OF CEMETERY OR CREMATORY New Cathedral		23d LOCATION CITY OR TOWN: Baltimore City, COUNTY: Maryland, STATE: Maryland					
24 FUNERAL DIRECTOR NAME: Ambrose Funeral Home, Inc. 1328 Sulphur Spring				ADDRESS: 21227		25a DATE REC'D. BY REGISTRAR: AUG 14 1987					
25b REGISTRAR'S SIGNATURE [Signature]											

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

065241 AUG 15 04

Page 4 of 20

063886 AUG 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22548
22548
REG. NO.1. FOR
STATE
REGISTRAR2. DECEASED NAME
(PLEASE PRINT)

FIRST

MIDDLE

LAST

THOMAS

CAPERS

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
08 24 87 1.30p M.

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH DAY YEAR
5-15-23

6. AGE (IN YEARS LAST BIRTHDAY)

64 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

South Carolina

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10. CITY OR TOWN OF DEATH

CITY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

BON SECOURS Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

md.

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

766 Carroll St. 21230

14. FATHER'S NAME

FIRST MIDDLE LAST
Thomas

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Bertha Jackson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

250-28-8711

17. INFORMANT

REBECCA CAPERS

ADDRESS

766 Carroll St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CEREBRAL Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) ARTERIOSCLEROTIC CARDIOVASCULAR Disease

DUE TO, OR AS A CONSEQUENCE OF

(c) RENAL Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

07/17 87 08/24 87

22a. I certify that (I) (this hospital) attended the deceased from 8/24 19 87 to 08/24 19 87, that (I) (we) lost

saw the deceased alive on 8/24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

08/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

KUANG-YEN HUANG

22e. ADDRESS

BON SECOURS Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8-27-87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem. Balto.

23d. LOCATION

CITY OR TOWN COUNTY STATE

Balto. Md.

24. FUNERAL DIRECTOR

NAME

Brown-Thompson F.H.

ADDRESS

1913 W. Balto. St.

25a. DATE REG'D BY REGISTRAR

AUG 25 1987

25b. REGISTRAR'S SIGNATURE

Julia Dondan-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19 25 204 0 0 0 0 0 0

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
2a. DECEASED NAME (TYPE OR PRINT)					2b. DATE OF DEATH		2c. MONTH		2d. DAY	2e. YEAR
Thelma Anna Cappelletti					August 5, 1987				a. m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		February 4 1911		76 YRS		MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore City				MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		3018 Chesterfield Ave. 21213		Housewife						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3018 Chesterfield Ave. 21213		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
John Brandt		MARGARET Booker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		212-28-8953		Frank Cappelletti		3018 Chesterfield Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Hypertension, left Bundle Branch Block</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
X				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>12-30</i> , 19 <i>86</i> , to <i>8-5</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8-4-87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
<i>John C. Hyle M.D.</i>						<i>8-6-87</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Dr. John C. Hyle M.D.		7527 Belair Road		Baltimore, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		Aug. 8, 87		Baltimore Cemetery		Baltimore Maryland				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Leonard J. Ruck, Inc.		Baltimore, Maryland		AUG 7 1987		<i>Julia Davidson-Ruck</i>				

062013 AUG-08-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22550

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond CARR			2a. DATE OF DEATH MONTH DAY YEAR 08 04 87		2b. HOUR 9 35 PM	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 28 09		
6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 77		8. IF UNDER 24 HRS. HOURS MIN. 77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
12b. KIND OF BUSINESS OR INDUSTRY Farmer		13a. STATE MD		13b. COUNTY Baltimore		
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1615 Park Avenue 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Harrison Clinton Carr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy May Chaney		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 216-48-8181		17. INFORMANT George Carr - Davidsonville 21035		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CAR-DIOPHGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a PNEUMONIA VENTRICULAR ARRHYTHMIA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/4 P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 8/3 , 19 87 , to 8/4 , 19 87 , that (I) (we) lost saw the deceased alive on 8/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE BICH T DUONG		
22c. DATE SIGNED 8-4-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG		22e. ADDRESS LIBERTY MEDICAL CENTER		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Baldwin Mem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Millersville AA. MD		23e. DATE REC'D. BY REGISTRAR AUG 06 1987		23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel Annapolis MD						

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. The first part of the report is a description of the project. It is a study of the effects of the new tax law on the economy. The study is being conducted by the Federal Reserve Board. The results of the study will be published in a report to the President. The report will be published in the next few months. The study is being conducted by the Federal Reserve Board. The results of the study will be published in a report to the President. The report will be published in the next few months.

2. The second part of the report is a description of the methodology used in the study. The study is a quantitative study. It uses a sample of 1000 households. The sample is representative of the population. The study is being conducted by the Federal Reserve Board. The results of the study will be published in a report to the President. The report will be published in the next few months.

63653 AUG 25 1987

Accr. Info. FilmG668 10/1/90 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22551
22551
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANOR LOUISE CARSON			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 20, 1987		2b. HOUR 1;28P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY 'MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. County	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Roy Echternach			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Carter				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 106-18-0937			17. INFORMANT Longmeadow Mass. 01106 Sarah Freedberg, 48 Converse St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). - Therapeutic Misadventure PART I. DEATH WAS CAUSED BY: 9289 IMMEDIATE CAUSE (a) pericardial tamponade DUE TO, OR AS A CONSEQUENCE OF (b) right umbilical laceration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) cardiomyopathy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 30 min 2-3 mo.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no								
19a. DATE OF OPERATION 1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiomyopathy		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR unk P.M. 8/20/87 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Laceration during biopsy				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Johns Hopkins Hosp		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 600 Broadway, Baltimore, Md. 21205				
22a. I certify that (I) (the hospital) attended the deceased from 12:00 PM 19 87 to 6:00 19 87 that (I) (we) last saw the deceased alive on 8/20/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.								
22b. SIGNATURE Kenneth Baughman		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/20/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH BAUGHMAN M.D.		22e. ADDRESS 600 N. WOLFE ST. BALTO., MD. 21205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25a. DATE REC'D BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED ON APPROVAL DR. P. SMYTH PER MR. LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other unusual condition, the medical examiner must be notified at once.

BP

83023 AUG 22 81

100-24-1001
JUN 24 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (PRINT) CHARLES C. CARTER			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7-31-87			2b. HOUR M 7:35P		
3. SEX M			4. RACE B			5. DATE OF BIRTH MONTH DAY YEAR 12-5-12		
6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city			10. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city			11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city		
12. CITY OR TOWN OF DEATH Baltimore			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2000 W. North Avenue			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE AT ON) md			16. STATE md			17. COUNTY md		
18. CITY OR TOWN Baltimore			19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20. STREET ADDRESS 2000 W. North Ave.		
21. FATHER'S NAME FIRST MIDDLE LAST unknown			22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			23. SOCIAL SECURITY NO. 226-05-2133		
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			25. SOCIAL SECURITY NO. 226-05-2133			26. INFORMANT OFFICER KIM -B.P.D. 731 Unit		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22b. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Margie A. Korell		TITLE (SPECIFY) Assistant		DATE SIGNED 8-6-87	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-11-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. L. Taylor-Rodriguez	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

AUG 24 1987

064131 AUG 58 01

2025 COLLECTIONS

000 MATH

062423 AUG

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 5 5 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Gladys E. LAST: Carter			2a. DATE OF DEATH MONTH: 8 DAY: 7 YEAR: 87			2b. HOUR 12 ⁴⁷ PM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH: 2 DAY: 6 YEAR: 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST: CORLEY MIDDLE: LAST: WILLIAMS			15. MOTHER'S MAIDEN NAME FIRST: MIDDLE: LAST:			13e. STREET ADDRESS / ZIP CODE 1447 Broening Highway 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213 346 687		17. INFORMANT ADDRESS: PENSACOLA, MD. DR. ROBERT CARTER 3755 PREYER AVE				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmias DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Presumed myocardial ischemia DUE TO, OR AS A CONSEQUENCE OF (c) Biventricular cardiomyopathy								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive lung disease; congestive heart failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) this hospital attended the deceased from 8/7 1987, to 8/7 1987, that (I) (we) lost saw the deceased alive on 8/7 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)									
22b. SIGNATURE M. Beine MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Beine MD						22e. ADDRESS Mercy Hospital Baltimore MD 21203			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/7/87		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vets		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md.		
24. FUNERAL DIRECTOR NAME: CARLTON C. DOUGLASS 1701 McCall St. ADDRESS: 1701 McCall St.						25. DATE REC'D BY REGISTRAR AUG 11 1987			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a police report filed.

1. The first part of the report is a summary of the work done during the year. It is a brief statement of the results of the work, and is intended to give a general idea of the progress made.

064254 AUG 31 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

August 26 1987 4:45P M

DECEASED NAME FIRST MIDDLE LAST
Vernice G. Carter

3 SEX FEMALE 4 RACE BLACK 5. DATE OF BIRTH MONTH DAY YEAR 11 11 1915 6 AGE (IN YEARS LAST BIRTHDAY) 71 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.

10 CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME NURSING AIDE 12b KIND OF BUSINESS OR INDUSTRY PVT. FAMILIES

13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN BALTIMORE 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE BALTO, MD. 21201 901 PENNSYLVANIA AVE. APT. 3D

14 FATHER'S NAME FIRST MIDDLE LAST JAMES RILEY 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE WALKER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO. 16b SOCIAL SECURITY NO. 212-22-2890 17 INFORMANT ADDRESS BALTO, MD. 21201 Verna L. Squirrel Same as above

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutesDUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
History of 2 myocardial infarctions, congestive heart failure, peripheral vascular disease, hypertension, metastatic carcinoma of liver, primary unknown19a DATE OF OPERATION August 24, 1987 19b COMBINATION FOR WHICH OPERATION WAS PERFORMED Acute occlusion of the left superficial femoral artery 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d INJURY OCCURRED WHILE ☐ AT WORK NO ☐ WHILE ☐ AT WORK NO ☐ 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (this hospital) attended the deceased from August 17, 1987, to August 26, 1987, that (we) last saw the deceased alive on August 26, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.

22b SIGNATURE Michael Diamiano MD DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c DATE SIGNED 8/27/87

22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Diamiano, M.D. 22e ADDRESS C/O Maryland General Hospital

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 8/31/87 23c NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM. 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.

24 FUNERAL HOME NAME ADDRESS FUNERAL HOMES INC, 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216 25a DATE REC'D BY REGISTRAR AUG 28 1987 25b REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, a medical examiner must be notified at once.

064521 AUG 31 81



AUG 31 1981

064248

AUG 31 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 2 5 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Georgia Virginia CEASER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 27, 1987		2b. HOUR 12:45a M
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 3 6 91		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Hazel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Hazel		13e. STREET ADDRESS / ZIP CODE 3802 Calloway Avenue 21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-03-9618		17. INFORMANT ADDRESS Agnes Poles 3802 Calloway Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ELECTROLYTE DISTURBANCE</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>GANGRENE OF THE LEFT LEG</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <u>AUGUST 24,</u> 19 <u>87</u> , to <u>AUGUST 27,</u> 19 <u>87</u> , that (X) (we) last saw the deceased alive on <u>August 27,</u> 19 <u>87</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE <u>Jose B. Valledon MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jose B. Valledon</u>		22e. ADDRESS <u>c/o MARYLAND GENERAL HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/87		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown MD		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue			
25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.BP 28
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

084548 AUG 31 03

4



10/10/03

10/10/03

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

22556

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Louise Michaels Chandler			2a DATE OF DEATH MONTH DAY YEAR Aug. 3 1987		2b HOUR 0220 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE MD	13b COUNTY	13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 830 W. 40th St. 21211	
14 FATHER'S NAME (TYPE OR PRINT) Urlwyn O. Michaels		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Hillman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 224 62 4538		17 INFORMANT ADDRESS Bliley Funeral Home, VA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRAINSTEM STROKE</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (he) (she) (it) attended the deceased from <u>AUG. 2</u> 19 <u>87</u> to <u>AUG. 3</u> 19 <u>87</u> that (we) (we) lost saw the deceased alive on <u>AUG. 2</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) not view the body after death.					
22b SIGNATURE <u>Ann A. Tran, MD</u>		DEGREE		22c DATE SIGNED 8/3/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Ann S. Tran M.D.		22e ADDRESS Union Memorial Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial	23b DATE 8/3/87	23c NAME OF CEMETERY OR CREMATORY Hollywood Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Richmond, VA	25a DATE REC'D. BY REGISTRAR AUG 04 1987	
24 FUNERAL DIRECTOR NAME Jenkins, H.J. 21212		25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

081330 WNE-283



20% COTTON FIBER

MADE IN U.S.A.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be examined by the notified official.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 2 2 5 5 7

REG. NO.

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

MAGGIE

CHAVIS

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

AUGUST 5, 1987

2:50 PM

3. SEX

FEMALE

4. RACE

B

5. DATE OF BIRTH

MONTH DAY YEAR

10/22/1810

6. AGE (IN YEARS LAST BIRTHDAY)

97

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARBORO, S. CAR.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

N/A

12b. KIND OF BUSINESS OR INDUSTRY

N/A

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALTO.

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1603 E. MADISON AVE. 21205

14. FATHER'S NAME

FIRST MIDDLE LAST

PETER SPEARS

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST

UNKN.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

N/A

17. INFORMANT

ADDRESS

251-18-1877 FLECIA DIGGS 1603 E. MADISON AVE.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 min.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) UROSEPSIS

72 hrs

DUE TO, OR AS A CONSEQUENCE OF

(c) SEVERE MALNUTRITION

6 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (i) (this hospital) attended the deceased from August 3, 1987, to August 5, 1987, that (ii) (we) lost saw the deceased alive on August 5, 1987, and that in (iii) (our) opinion death occurred on the date and hour and from the causes stated above; (iv) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ANDREA M. CORSE

22e. ADDRESS

630 N. WOLFE ST BALTIMORE, MD 21205

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/11/87

23c. NAME OF CEMETERY OR CREMATORY

EASTVIEW

23d. LOCATION CITY OR TOWN

BALTO., MD.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

LEROY O. DYETT 4600 LIBERTY HEIGHTS

25a. DATE REC'D. BY REGISTRAR

AUG 7 1987

25b. REGISTRAR'S SIGNATURE

John S. [Signature]

05103 JUL 10 81

100-100000

100-100000

064293 AUG 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										22558 REG. NO.	
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
		Alexander J. Chmielewski						8/ 26/ 87		M	
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD	2d. HOUR	
Male	White	Aug. 12 1902		85 YRS.					8/ 26/ 87	P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Johns Hopkins Hospital				Longshoreman		Steamship Trade Assn.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Baltimore				526 N. Linwood Ave. 21205			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Joseph Chmielewski				Laura Kwicka							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no				215-05-3275		Josephine Sobus - 6005 Sefton Ave.		21214			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: Multiple Injuries											
IMMEDIATE CAUSE (a) _____											
DUE TO, OR AS A CONSEQUENCE OF _____											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: _____											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF _____											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
				8:15xx 8/ 26/ 87		subject pedestrian struck by auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				street		Fayette St. & Kenwood Ave., Balto. City, Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion _____											
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
<i>Dennis F. Smyth</i>				Assistant				8/27/87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Dennis F. Smyth, M.D.				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		9/1/87		Holy Rosary		Baltimore Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCHIMUNEK FUNERAL HOME, INC.						AUG 28 1987		<i>Julia Anderson-Landale</i>			
3331 Brehms Lane, Balto Md. 21213											

07/84
25M

BP

DHMM - 17
(VR A15 ME (5))

084503 VNC 31 63



Actual results are 100.0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 5 5 9

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PRISCILLA CIUPINSKI CIOTTI			2a. DATE OF DEATH MONTH DAY YEAR August 2, 1987		2b. HOUR M
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 102 E. Melrose Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE Maryland	13b. COUNTY -----	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 102 E. Melrose Ave. 21212
14. FATHER'S NAME FIRST MIDDLE LAST Michael Ciupinski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Jabowski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-46-2378T		17. INFORMANT ADDRESS Priscilla Ciotti 102 E. Melrose Ave. 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Three</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>4/29</u> 19 <u>87</u> , to <u>8/3</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (we) did not view the body after death.					
22b. SIGNATURE <u>Stewart Bell</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/3/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stewart Bell		22e. ADDRESS 3501 St. Paul St. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-6-87	23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE <u>John Thomas Pender</u>	

2232 2011 11 27

[illegible]

062772 AUG-14-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH81 REG. NO. 22560
26 HOUR 7:20 PM

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence Clanton			2a. DATE OF DEATH MONTH DAY YEAR 8-5-87		2b. HOUR 7:20 PM		
3. SEX Male		4. RACE Blk.		5. DATE OF BIRTH MONTH DAY YEAR 7 17 24		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 43	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Bolt, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason Lord NH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE D		13b. COUNTY D		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MASON LORD NURSING HOME			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week Years.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Seizures, HTN, Dementia, Decubitus Ulcer**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Verdery		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Verdery		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-7-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board				25. DATE RECEIVED BY REGISTRAR 8/5/87			

025775 and 14 87



RECEIVED
MAY 10 1987

025775

14/12

062766

AUG 14 87

FOR Item 5,6 Film 6630 8-13-87
STATE REGISTRAR per phone FH SBSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 5 6 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BELLE CLARK			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 12, 1987		2b. HOUR 2:49 a.m.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3-15-1897		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mullins S. Caroln		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 90		
10. CITY OR TOWN OF DEATH BALITMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			12b. KIND OF BUSINESS OR INDUSTRY Nurse			
13b. COUNTY Balto			13c. CITY OR TOWN Balto			
14. FATHER'S NAME FIRST MIDDLE LAST George Fnday			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sissy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-22-1151			
17. INFORMANT NAME ADDRESS Izel Clark 3108 Leighton Ave						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4 days**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PNEUMONIA****13 days**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from JULY 29, 1987 to AUGUST 12, 1987 , that (we) last saw the deceased alive on AUGUST 12, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Pflugrath M.D.				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PFLUGRATH				22e. ADDRESS c/o Maryland General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/17/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Nat		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland	
24. FUNERAL DIRECTOR NAME James A. Martin				ADDRESS 1701-Lantern St		25a. DATE REC'D. BY REGISTRAR AUG 13/87	
				25b. REGISTRAR'S SIGNATURE John Davidson			

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

MEDICAL CERTIFICATION

005796 Kc 14 84

✱

063196 AUG 1987

REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 5 6 2

1. DECEASED NAME (TYPE OR PRINT) JAMES A. CLARK, III			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1987			2b. HOUR 11:15 A.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 8, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5918 YORKWOOD ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADM. ASS'T.		12b. KIND OF BUSINESS OR INDUSTRY FED. GOV'T.	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES A. CLARK, JR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE BOOTH		13e. STREET ADDRESS / ZIP CODE 5918 YORKWOOD ROAD 21239			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II 219032016		17. INFORMANT FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Evolving recurrent Myocardial DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) infarction DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 8/5/87 to 8/13/87 that (I) (attest) saw the deceased alive on 8/5/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we do) (did not) view the body after death.							
22b. SIGNATURE Nguyen		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED AUG. 14, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. VUONG VU NGUYEN		22e. ADDRESS 6331 BELAIR ROAD - BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-17-1987		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S-GOVAN'S		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES		ADDRESS 2325 YORK ROAD		25a. DATE REC'D. BY REGISTRAR AUG 18 1987			
25b. REGISTRAR'S SIGNATURE							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0631830

25

063068 AUG 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 2 5 6 3

REG. NO.

FOR
1- STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Katy B. Clark2a. DATE OF DEATH MONTH DAY YEAR
8-9-87 2b. HOUR
M

3. SEX

Female

4. RACE

Negro

5. DATE OF BIRTH

MONTH DAY YEAR
3-24-12

6. AGE (IN YEARS LAST BIRTHDAY)

75 YRS.

IF UNDER 1 YEAR IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

North Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Bon Secours Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4006 Maine Ave. 21207

14. FATHER'S NAME

FIRST MIDDLE LAST
KARA GAURDIAN SHAW

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Lular Jenrette

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
EVAN ELLEN PARKER 2708 BAKER ST 21216

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

stroke

pneumonia

urinary tract infection

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK ☐ AT HOME ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/9 19 87 to 8/9 19 87, that (I) (we) lost the deceased alive on 8/9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

CD Kearney MD

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

CHRISTOPHER D. KEARNEY

22e. ADDRESS

700 WASH. BLVD BALT MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8-15-87

23c. NAME OF CEMETERY OR CREMATORY

Kings Mem. Park

23d. LOCATION CITY OR TOWN

Balt.

COUNTY

Calvert

24. FUNERAL DIRECTOR

NAME

Russ Funeral Home

ADDRESS

2222 W. North Ave

25. DATE REC'D BY REGISTRAR

AUG 17 1987

25. PREPARED BY

Julia B. B. B.

003068 AUG 18 81

64261 AUG 31 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22564
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MINNIE C. CLARK			2a. DATE OF DEATH MONTH DAY YEAR 08 20 87		2b. HOUR 208 P.M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 22 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST GARFIELD JAMES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH HOLLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO.		16b. SOCIAL SECURITY NO. 212-44-2388		17. INFORMANT MRS. RANDALLSTOWN, MD. VENTRICE CLARK BETHEA 9626 MENDOZA RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/20/87</u> , 19 <u>87</u> , to <u>8/20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>P. Becker</u>				22c. DATE SIGNED 8/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BECKER				22e. ADDRESS 22 S. GREENE ST BALTIMORE 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/25/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. RK	
24. FUNERAL DIRECTOR NAME Nutter Funeral Homes, INC.		ADDRESS 2501 Gwynns Falls Pkwy		25a. DATE REC'D. BY REGISTRAR AUG 28 1987	
25b. REGISTRAR'S SIGNATURE <u>De. R. L. Anderson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and place them in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

064014 AUG 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22565

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
Theresa Clark				August 24, 1987		5	
3. SEX	F	4. RACE	W	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
				Feb. 14, 1897	90		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH	Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		6117 Edlynn Road		Homemaker			
13a. STATE	Md.	13b. COUNTY	Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST		Alois Sittka		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
				Maria Palatar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	212 48 5328	17. INFORMANT ADDRESS			
				Mr. Louis Thuman 6117 Edlynn Rd. 21239			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> , 19 <u>87</u> , to <u>8/24</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>8/4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Nestor M. Carmone</u>		DEGREE M.D.		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
NESTOR M. CARMONE		6012 Habl M. Bldg, Balt, 21214					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	8/26/87	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
				Holy Redeemer		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR			
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.				AUG 26 1987			
				25b. REGISTRAR'S SIGNATURE <u>Julia Swanson-Rodriguez</u>			

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FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22566
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELMIRA V. CLARKE			2a. DATE OF DEATH MONTH DAY YEAR 8 9 87		2b. HOUR 7:05AM
3. SEX FEMALE	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 05 17 08		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 2328 MADISON AVE. 21217					
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT HOLMES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE WATSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 134-18-1446		17. INFORMANT ADDRESS ALVA KARLAND 84-19 51st AVE. ELMHURST, NY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9th Aug</u> 19 <u>87</u> , to <u>9th Aug</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9th Aug</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Antony C. Dike, MD</u>		DEGREE MD		22c. DATE SIGNED 8/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY C. DIKE, MD		22e. ADDRESS LIBERTY MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8/12/87		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEM.	
23d. LOCATION CITY OR TOWN COUNTY BALTIMORE, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 12 1987 <u>John D. ...</u>			
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.					

MEDICAL CERTIFICATION

9/9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

2 2 5 6 7

1. DECEASED NAME (TYPE OR PRINT) Viola Strayhorn Clarke			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-21 1987			2b. HOUR M 12:00 P		
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 20 1907	6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 8-21 1987	2d. HOUR M 12:00 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4308 Ethland Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Balto. Md. Apt. 1006 1600 W. Mount Royal Ave. 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 213-34-3062D		17. INFORMANT Baltimore, Maryland June Booker 4308 Ethland Avenue 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic cardiovascular</u> xxxxxxxxxxxxxx disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Charles P. Kokes</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 8-22-87		
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.			ADDRESS 111 Penn St., Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/26/1987		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL HOME NAME ADDRESS Funeral Homes, Inc. 2501 Gwynn Falls Pkwy. Baltimore, Md. 21216					25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 5 SHOULD BE FILED WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22568

REG. NO.

1- STATE GISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST DONALD		MIDDLE HUGHES		LAST CLAYTON		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 8-1-87 19		2b. HOUR M	
3 SEX M		4 RACE B2		5 DATE OF BIRTH MONTH DAY YEAR 10 25 58		6 AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 8-1-87 19 7AM M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10 CITY OR TOWN OF DEATH Baltimore				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1410 N. Montford(rear)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b KIND OF BUSINESS OR INDUSTRY CLOVERLAND	
13a STATE MD				13b COUNTY		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1210 N. DECKER STREET 21213			
14 FATHER'S NAME FIRST MIDDLE LAST ERVIN CLAYTON				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCINDA E. JONES				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b SOCIAL SECURITY NO. N/A	
17. INFORMANT ADDRESS LUCINDA E. CLAYTON 1210 N. DECKER AVE				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stab wounds of chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8-1-87 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed during an altercation					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f LOCATION STREET CITY OR TOWN COUNTY STATE 2600 E. Preston Street Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TIME (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 8-1-87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 8/5/87		23c NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY				23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD			
24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.				ADDRESS 1101 E. NORTH AVE.				25a DATE REC'D. BY REGISTRAR AUG 04 1987				25b REGISTRAR'S SIGNATURE <i>Julia Dendron-Randolph</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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AUG 04 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 22569			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Glascoe W. Claxton				2a. DATE OF DEATH MONTH DAY YEAR 8 25 87		2b. HOUR 2:10 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 21 19		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GLASCOE P. CLAXTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE WILLIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 218-07-7117		17. INFORMANT ADDRESS VIRGINIA LOWRY 703 EAST 21st STREET					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Seizure and Cerebellar Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <u>14 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, EARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (this hospital) attended the deceased from <u>8/11</u> , 19 <u>87</u> , to <u>8/25</u> , 19 <u>87</u> , that (we) lost saw the deceased alive on <u>8/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Earl Stokes IV</u> THE PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/25/87	
22d. ADDRESS The Union Memorial Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/29/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS, MD	
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.				25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE <u>Frederick Anderson</u>	

064183-1031430



20% COTTON FIBER

CHIEFMAN BRAND

WAB 33 B&B

2 GR.
063788 AUG 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22570
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dennis K. Clinton			2a. DATE OF DEATH MONTH DAY YEAR 08/20/87			2b. HOUR 1:55 PM				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 05 52		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS		7. UNDER 1 YEAR MONTHS DAYS 7. UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (COUNTRY) Md		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md Hospital			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balt. 13c. CITY OR TOWN Baltimore		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 810 Attendale St. 21229						
19. FATHER'S NAME FIRST MIDDLE LAST Wesley Clinton		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie McArthur								
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		22. SOCIAL SECURITY NO. 214-56-3634		23. INFORMANT ADDRESS Annie Clinton 810 Attendale Street						
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac and Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis, Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HIV</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none 2-4 hrs Months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic Active Hepatitis & Cirrhosis</u>										
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE						
35. I certify that (a) this hospital attended the deceased from August 19 87 to August 20 87 that (b) we saw the deceased alive on August 20 19 87, and that in my opinion death occurred on the date and hour and from the causes stated above, (c) we did not view the body after death.										
36. SIGNATURE Steven Dellon				37. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			38. DATE SIGNED 8/20/87			
39. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Dellon, M.D.				40. ADDRESS 22 S. Greene St. Baltimore, MD 21201						
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		42. DATE 8/25/87		43. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		44. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co MD				
45. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue				46. DATE REC'D. BY REGISTRAR AUG 24 1987		47. REGISTRAR'S SIGNATURE				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22571

REG. NO.

FOR STATE REGISTRAR			20. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) Lillian B. COAKLEY			08 12 87			1:00 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 01 09 93	6. AGE (IN YEARS (LAST BIRTHDAY)) 94 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Wesley Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown			12b. KIND OF BUSINESS OR INDUSTRY unknown		
13a. STATE MD			13b. COUNTY Balto.			13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST George W. Bowen, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Jane Hutchins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212-03-1547			17. INFORMANT ADDRESS Wesley Home, Inc 2211 W. Rogers Avenue		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) SIP CVA

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Sip Relent E. Coli Sepsis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>87</u> , to <u>8/12</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert J. Liberto, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT LIBERTO, M.D.</u>				22e. ADDRESS <u>22 W Rogers Ave. Balto, Md.</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-15-87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home 3631 Falls Rd.							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

005050 AUG 18 95

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) LAURA B COE					2a. DATE OF DEATH MONTH DAY YEAR 8-22-87			2b. HOUR 4:45^P		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9-13-27		6. AGE (IN YEARS (LAST BIRTHDAY)) 59 YRS		# UNDER 1 YEAR MONTHS DAYS 59		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BLADEN CO., N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.				
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MED. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4113 BONNER RD. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK WRIGHT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET MC ALLISTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS GLORIA WATERS 3159 LYNDAL ST. 21213						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DIABETES										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-15-87 to 8-22-87 , that (I) (we) last saw the deceased alive on 8-22-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N. RAIKER					22e. ADDRESS L MC.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/28/87		23c. NAME OF CEMETERY OR CREMATORY EASTVIEW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT & SON 4600 LIBERTY HEIGHTS					25a. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22573

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Anna MIDDLE: Lee LAST: Coffman			2a. DATE OF DEATH MONTH DAY YEAR 08-30-87		2b. HOUR 11:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 29 43		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 202 Blannen Rd 21061
14. FATHER'S NAME FIRST: Sullivan MIDDLE: NMN LAST: Alger		15. MOTHER'S MAIDEN NAME FIRST: Evelyn MIDDLE: Jane LAST: Foster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) XXXXXXX Y Vietnam		16b. SOCIAL SECURITY NO. 215-42-3530		17. INFORMANT Sullivan, Alger, Sr. Prec. Registrar - Frederick, MD 21701	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Cardioresg Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b). <u>Inherent. Bleed</u> DUE TO, OR AS A CONSEQUENCE OF (c). <u>Cerebral tumor</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-25, 19 87, to 8-30, 19 87, that (I) (we) last saw the deceased alive on 8-30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregory P. Midon		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory P. Midon		22e. ADDRESS 22 S. Green St. Balt. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/1/87	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bolivar, Jefferson, W. Va.	
24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, WV 25425		25a. DATE REC'D. BY REGISTRAR SEP 3 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

062638 AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22574

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ELIZABETH

COHEN

2a. DATE OF DEATH

MONTH

DAY

YEAR

AUGUST 6, 1987

2b. HOUR

5A.

M

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

JULY 22, 1907^R

6. AGE (IN YEARS LAST BIRTHDAY)

80

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

6317 PARK HTS. AVE., APT. 611

12a. USUAL OCCUPATION

HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

HOMEMAKER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

6317 PARK HTS. AVE., APT. 611

(21215)

14. FATHER'S NAME

EDWIN

MIDDLE

LAST

STERNBERGER

15. MOTHER'S MAIDEN NAME

ELLA

MIDDLE

LAST

WOLFRAM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

250-82-3664

17. INFORMANT

ADDRESS

21208

MRS. LOIS GREENEBAUM 1 WHITEBRIDGE CT.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

MULTIPLE CEREBROVASCULAR ACCIDENTS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

ASPIRATION PNEUMONITIS; SEPSIS

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) the deceased attended the deceased from 8/6 1987 to 8/6 1987, that (2) I last saw the deceased alive on 8/6 1987, and that in my opinion death occurred on the date and hour and from the causes stated above, (3) we (4) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8/6/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

HOWARD B. COHEN

22e. ADDRESS

6610 CROSS COUNTRY BLVD.

23a. BURIAL AND REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/7/87

23c. NAME OF CEMETERY OR CREMATORY

K.K. BETH ELOHIM CEM

23d. LOCATION

CITY OR TOWN

CHARLESTON

COUNTY

SOUTH CAROLINA

24. FUNERAL DIRECTOR

SOL LEVINSON & BROS., INC.

6010 REISTERSTOWN RD. BALTO, MD 21215

25a. DATE REC'D BY REGISTRAR

AUG 12 1987

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

005838 WIG 1301



062608 AUG 13 1987

FOR Items 5,15 Film G631 9-8-87 SR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 / REG. NO. 22575

1 DECEASED NAME (TYPE OR PRINT) Charles E. Cole			2a DATE OF DEATH MONTH DAY YEAR 8 7 1987		2b HOUR M
3 SEX male	4 RACE black	5. DATE OF BIRTH MONTH DAY YEAR 9 2 1925		6 AGE (IN YEARS LAST BIRTHDAY) 61 60 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 410 Gwynn Avenue		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Md			13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John Chambers		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Cole Brooks			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b SOCIAL SECURITY NO. 215-20-2823	17 INFORMANT Lois Cole 410 Gwynn Avenue			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pancreatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>5-29-87</u> , 19 <u>87</u> , to <u>8-7-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8-5-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>GORMLEY</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>8/10/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>GORMLEY</u>		22e ADDRESS <u>900 Canton Ave Balto</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 8/13/87	23c NAME OF CEMETERY OR CREMATORY Arbutus Mem Park		23d LOCATION CITY OR TOWN COUNTY STATE Arbutus MD	
24 FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25a DATE REC'D. BY REGISTRAR AUG 11 1987			
		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

065208 AUG 13 61

25212

POSTAL TELEGRAPH

BRITISH

POSTAL TELEGRAPH



POST 11 11 11

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22576

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR			
Burley		Coleman						8/ 2/ 19 87										11:06 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
M		B		1 8 47		40 YRS.		MONTHS		DAYS		HOURS		MIN.		8/ 2/ 19 87					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
MD				U.S.A.								Baltimore City, MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore				Johns Hopkins Hospital				LABORER				NURSING HOME									
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS					
MD								BALTO.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3802 KIMBLE ROAD 21218					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
CHARLES				COLEMAN				LELIA				B. CROSBY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
YES				212-44-7087				THERESA COLEMAN				3802 KIMBLE ROAD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE				Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 8/3/87									
EXAMINER'S NAME (TYPE OR PRINT)				Dennis F. Smyth, M.D.				ADDRESS 111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY STATE					
BURIAL				8/7/87				GARRISON FOREST				OWINGS MILLS,				MD					
24. FUNERAL DIRECTOR NAME ADDRESS																		25. DATE RECEIVED BY REGISTRAR		26. REGISTRAR'S SIGNATURE	
WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.																		AUG 06 1987		Julia Benson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE COMPLETED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 19. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 101 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

07/B4
25M

BP_____

DHMH - 17

(VR AIS ME (5))

061381 WAG-831

3 5 2 7 6

1981 00 80A

63071 AUG 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22577

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORISE D.C. COLEMAN			2a. DATE OF DEATH MONTH DAY YEAR 8/15/87		2b. HOUR MIN. 7:35 A.M.				
3. SEX male		4. RACE Col. 2		5. DATE OF BIRTH MONTH DAY YEAR 6-1-1910		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 77			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fayetteville N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Gen Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction worker		12b. KIND OF BUSINESS OR INDUSTRY			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME LAST FIRST MIDDLE Dorise Coleman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minrice Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 214-09-8839A	
17. INFORMANT NAME Mrs. Eva Coleman			ADDRESS 1570 Moreland Ave. 21216						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/15 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/4 19 87 to 8/15 19 87 , that (I) (we) last saw the deceased alive on 8/15 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marcos B. Galicia, M.D.				DEGREE M.D.			22c. DATE SIGNED 8/15/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA				22e. ADDRESS North Charles General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-22-87		23c. NAME OF CEMETERY OR CREMATORY Brown's Cem. II		23d. LOCATION CITY OR TOWN COUNTY STATE Williamstown, N.C.			
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2222 W. North Ave.		25a. DATE REC'D. BY REGISTRAR AUG 17 1987		25b. REGISTRAR'S SIGNATURE Julia Bender-Rudolph	

MEDICAL CERTIFICATION

229

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an official, physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

2577
1/12/87

Dr. J. H. ...

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064057 AUG 28 87

 Items, 18a., 21a.-22a., G-631, Med. Exam., STATE OF MARYLAND
 FOR
 STATE 9/15/87, Gbj.
 REGISTRAR

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22578

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Mark						Coleman		8/		20/19		87				M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		7d. HOUR	
MALE		BLACK		8 16 66		21 YRS.						8/ 20/19 87		6:37		A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		U.S.				Baltimore City,										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Maryland Penitentiary															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
MARYLAND				BALTIMORE				21229 3609 GEISTON DRIVE									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Richard Coleman		Gwendolyn Gassaway						CHART									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 7999 IMMEDIATE CAUSE (a) Hanging Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 20 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) jail cell		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Maryland Penitentiary, Baltimore City, Maryland													
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		DATE 8/20/87		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-25-87		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD							
24. FUNERAL DIRECTOR NAME ADDRESS E.L. Phillips 1721 N. MONROE ST.		25a. DATE REC'D BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25A
 DHMH - 17
 (VR A15 ME (5))

084022 102381



UNION VIKI-1010

92811-10100-102

100 31 001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed by the attending physician and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon from page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22579

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE COLES			2a. DATE OF DEATH MONTH DAY YEAR 8 14 87			2b. HOUR 9³⁰ A.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 30 91		6. AGE (IN YEARS LAST BIRTHDAY) 95		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1521 PENTRIDGE ROAD 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Jenny Poole			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Wood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-09-8916		17. INFORMANT ADDRESS Joyce Sykes 4109 Chatham Rd. 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO - PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE - RENAL FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Karl Salzman				DEGREE M.D.				22c. DATE SIGNED 8/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARL SALZMAN				22e. ADDRESS SINAI HOSPITAL - BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-19-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cmty. Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE ABA Co. Md.			
24. FUNERAL DIRECTOR NAME Randolph J. Collick				ADDRESS 2431 E. Oliver St.		25a. REG. NO. AUG 21 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

1982 JUL 08 23 04

063252 AUG 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22580

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE COLEY JR.			2a. DATE OF DEATH MONTH DAY YEAR 8/14/87			2b. HOUR 8:55 AM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 29 14		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bethlehem Steel		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY CITY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE SA. COLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BIRDIE HAEK		13e. STREET ADDRESS / ZIP CODE 2749 RIGGS AVE. 21216			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 237241852		17. INFORMANT ADDRESS FRANCES COLEY 2749 RIGGS AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CARCINOMA LEFT LUNG APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: BLEEDING FROM THE TUMOR OF THE LEFT LUNG.							
19a. DATE OF OPERATION 8/2/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MASSIVE BLEEDING FROM TUMOR OF THE LEFT LUNG.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/2 1987 to 8/14 1987			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE GARTH AS. SAMUELS		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARTH AS. SAMUELS		22e. ADDRESS 6011 PARK HEIGHTS AVE. BALTIMORE MD 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/20/87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE, MD	
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.				25a. DATE REC'D. BY REGISTRAR AUG 19 1987			
				25b. REGISTRAR'S SIGNATURE Julia Peniston Radabaugh			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 1B above any injury, or other traumatic event, the medical examiner must be notified through the coroner.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

003525 AUG 50 01

[Faint, mostly illegible handwritten text on lined paper. Some words like "COTTON" and "COTTON" are visible in the left margin.]

01 BUA

063236 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 2258
2a. DATE OF DEATH MONTH DAY YEAR 8 18 87
2b. HOUR 320 PM1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CAMILLO E. COLLETTA3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 26, 1913 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.10. CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY HOSP 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Social Security Adm. 12b. KIND OF BUSINESS OR INDUSTRY13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 3007 Grindon Ave. 21214

14. FATHER'S NAME FIRST MIDDLE LAST Arcangelo Colletta 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gemma DeBenedictis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no 16b. SOCIAL SECURITY NO. 091-03-8802 17. INFORMANT ADDRESS Ave. Mr. Francis J. Colletta Sr. 3317 Rosekemp

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: 8702 IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SMOKE INHALATION INJURY 8 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
HISTORY OF CARDIAC ARRYTHMIA & PULMONARY EDEMA19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30 PM 8 11 1987 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) House fire ACCIDENT21d. INJURY OCCURRED WHILE ☒ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3007 GRINDON AVE BALTIMORE MD

22a. I certify that (I) (this hospital) attended the deceased from Aug 11 1987 to Aug 18 1987, that (I) (we) last saw the deceased alive on Aug 18 1987, and that in (my) (our) opinion death occurred on the date and hour stated, and the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE AP Cunninham MD DEGREE MD 22c. DATE SIGNED 8/18/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BP CUNNINHAM MD 22e. ADDRESS FRANCIS SCOTT KEY HOSP BALTIMORE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE Aug. 22, 1987 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.

24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland 25a. DATE REC'D. BY REGISTRAR AUG 19 1987 25b. REGISTRAR'S SIGNATURE

063538 AUG 30 87

228 COTTON FIELD

RECEIVED

AUG 18 1987

063614 AUG 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22582

1. DECEASED NAME (TYPE OR PRINT) ALONZO COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 8/10/87		2b. HOUR 1:45 A.M.
3. SEX M	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 7/3/10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD. MEDICAL SYSTEM		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY BALT.	13c. CITY OR TOWN BALT.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UK		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSPITAL CHART 22 S. GREENE ST. BALT.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ELECTROMECHANICAL DISSOCIATION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>CARDIAC ARRYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>END CHRONIC OBSTRUCTIVE PULMONARY DISEASE - EMPHYSEMA</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PERITONITIS 2° TO PERFORATED DUODENAL ULCER</u>					
19a. DATE OF OPERATION 8/8/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED DUODENAL ULCER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 8/8/87 to 8/10/87, that (1) I have lost saw the deceased alive on 8/10/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (I) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED 8/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.J. VAYOR JR. M.D.		22e. ADDRESS 22 S. GREENE ST. BALT. MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-17-87		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME State Anatomy Board		24b. REGISTRAR'S SIGNATURE AUG 24 1987 Julia Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified promptly.

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062379 AUG 1 1987 FOR REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22583

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Betty Jane COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 8 5 87		2b. HOUR 8:55 AM	
3. SEX F		4. RACE C White		5. DATE OF BIRTH MONTH DAY YEAR 6 18 34		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 53 IF UNDER 1 YEAR MONTHS DAYS 1 17		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---				
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4740 Aldgate Green, 21227				
14. FATHER'S NAME FIRST MIDDLE LAST Warren E. Stearns		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ridgley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-34-6238		17. INFORMANT ADDRESS Russell W. Collins, Sr., 4770 Aldgate Green		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST - RIGHT HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES MONTHS YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>MITRAL VALVE PROLAPSE</u>						
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR <u>8:30</u> MONTH <u>8</u> DAY <u>5</u> YEAR <u>1987</u> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> 19 <u>87</u> to <u>8/5</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/5</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Henry J. Chen</u>		22c. DATE SIGNED 8/5/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY J. CHEN		22e. ADDRESS 22 S. GREENE ST, BALTIMORE, MD, 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		
23d. LOCATION CITY OR TOWN Elkridge		23e. COUNTY Howard		23f. STATE Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		24b. ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR AUG 07 1987		
25b. REGISTRAR'S SIGNATURE <u>Julia...</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers, pages 1 and 2, and should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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AUG 07 2005

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

*TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, together with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. 22584

1. DECEASED NAME (TYPE OR PRINT) CATHERINE C. COLLINS			2a. DATE OF DEATH MONTH DAY YEAR August 29, 1987		2b. HOUR 1 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 13, 1906		6. AGE (IN YEARS, LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michael		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL COUGHLAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH WEDAMSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-01-2555		17. INFORMANT ADDRESS RAY EHRHART 8903 KILKENNY CIR. BALTO. MD. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Harold Bob M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 08-30-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD BOB M.D.		22e. ADDRESS 7220 Park Heights 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/1/87	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND
24. FUNERAL DIRECTOR NAME LeRoy M. & Russell Witzke Funeral Hn.			25a. DATE REC'D. BY REGISTRAR AUG 31 1987		
1630 Edmondson Ave. Catonsville MD 21228			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22585
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
GLENDORA COLLINS				AUGUST 3, 1987		10:30A	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE	BLACK	MONTH DAY YEAR 3 2 23		64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD	U.S.A.			BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			DOMESTIC		N/A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
WILLIAM COLLINS Sr.		PRISCILLA BROOKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		220-22-3405		WILLIAM COLLINS JR. 714 N. MONTFORD AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>brain stem infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heat stroke</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 week</u> <u>1 week</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) this hospital attended the deceased from <u>7/25</u> , 19 <u>87</u> , to <u>Aug 3</u> , 19 <u>87</u> , that (b) (we) last saw the deceased alive on <u>Aug 3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Jonathan Schaleschein</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JONATHAN SCHALESCHIN		600 N. WOLFE STREET		21205			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		8/8/87		BALTIMORE CEMETERY		BALTIMORE, MD	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.				AUG 7 1987		<u>John Fisher-Baker</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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PROCESSED
AUG 11 1981

AUG 1 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 2 2 5 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT A. COLLINS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 20, 1987		2b. HOUR P 5:00 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 3 1972		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE, DUTY OR FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE North Carolina		13b. COUNTY Richmond		13c. CITY OR TOWN Rockingham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert B. Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara McCormick		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. 241-27-3465	
17. INFORMANT Robert B. Collins		ADDRESS North Carolina		18. STREET ADDRESS / ZIP CODE 1904 Eason Drive 99999			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coagulopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5 Days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a: <u>relapsed acute lymphocytic leukemia, renal failure</u>							
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19 <u>87</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>		22a. I certify that (I) (the hospital) attended the deceased from <u>8-11</u> , 19 <u>87</u> , to <u>8-20</u> , 19 <u>87</u> , that (I) (the hospital) saw the deceased alive on <u>8-20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Janis Lacovara</u>		22d. ADDRESS <u>JHH 600 N WOLFE ST Baltimore MD 21210</u>		22e. DATE SIGNED <u>8-20-87</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-24-87		23c. NAME OF CEMETERY OR CREMATORY Northam Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockingham, Richmond, North Car.	
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, MD.		25. DATE OF DEATH 8-20-1987		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87-22587
REG. NO.1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

Shirley

FIRST

MIDDLE

LAST

L.

Collins

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

8/7/87

1:35 P.M.

3. SEX

FEMALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH

DAY

YEAR

1

10

33

6. AGE (IN YEARS LAST BIRTHDAY)

54

7. UNDER 1 YEAR

8. UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

NY

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Union Memorial Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

UNEMPLOYED

12b. KIND OF BUSINESS OR INDUSTRY

N/A

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2618 E. PRESTON STREET 21213

14. FATHER'S NAME

ROBERT

MIDDLE

LAST

LATTIMORE

15. MOTHER'S MAIDEN NAME

MARIE

MIDDLE

LAST

HALL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

ADDRESS

AUDREY LATTIMORE 3723 ELMORA AVE.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ovarian Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

12/85 - 8/7/87

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/21 19 87 to 8/7 19 87, that (I) (we) last saw the deceased alive on 8/7/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

T.O'Brien

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

T. O'Brien, M.D.

22e. ADDRESS

Union Memorial Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/11/87

23c. NAME OF CEMETERY OR CREMATORY

EASTVIEW CEMETERY

23d. LOCATION

DUNDALK,

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.

25a. DATE REC'D. BY REGISTRAR

AUG 10 1987

25b. REGISTRAR'S SIGNATURE

John P. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATHREG. NO. 22588
2. DATE KNOWN OF DEATH MATED 8-1-87
3. DATE PRONOUNCED DEAD 8-1-87
4. HOUR 8:15a

5. DECEASED NAME (TYPE OR PRINT) TROY COLLINS		6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
9. SEX Male	10. RACE Black	11. DATE OF BIRTH MONTH DAY YEAR 1-31-67		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
14. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		15. CITIZEN OF WHAT COUNTRY? U.S.		16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 600 blk.W. Preston Street		17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21223	
18. CITY OR TOWN OF DEATH Baltimore		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 600 blk.W. Preston Street		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21223		21. KIND OF BUSINESS OR INDUSTRY	
22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY 13c CITY OR TOWN Baltimore		23. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24. STREET ADDRESS 118 S. Amity Street		25. FATHER'S NAME FIRST MIDDLE LAST Robert Collins	
26. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Maddox		27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		28. SOCIAL SECURITY NO. 220-86-7592		29. INFORMANT ADDRESS Geraldine Maddox 118 S. Amity St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Gunshot wound of chest

IMMEDIATE CAUSE (a) _____

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:25AM 8-1-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on the street		21f. LOCATION CITY OR TOWN COUNTY STATE 600 blk. W. Preston St. Baltimore, Maryland	

22a. I certify that took charge of the remains described above, held on death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinionACTUAL SIGNATURE *Dennis F. Smyth* TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 8-1-87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-7-87		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, MD	
24. FUNERAL DIRECTOR NAME ADDRESS Irvin Carroll 1712-14 W. North Avenue				25a. DATE REC'D. BY REGISTRAR AUG 04 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Swinton-Rodden</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM F-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFERMENT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

5-2-88

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 2 2 5 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Lenore Condry			2a DATE OF DEATH MONTH DAY YEAR August 10, 1987		2b HOUR 4:55 AM
3 SEX Female		4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a STATE Maryland		13b COUNTY A A Co.	13c CITY OR TOWN Glen Burnie	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George Turner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Rigglesman		12b KIND OF BUSINESS OR INDUSTRY Own Home	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17 INFORMANT (Son) James L. Condry		ADDRESS Same as #13
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio cerebral pathology, CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Dementia Wress - Recurrent pneumonia</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>8-10-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 8/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK		22e ADDRESS 5001 S. HANOVER ST. BACT. MZ			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug 13, 1987	23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md.
24 FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland		25a DATE REC'D. BY REGISTRAR AUG 11 1987	
				25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

005238 Y02 13 81

062541 AUG 13 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22590

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANGELA Mary CONNELLY			2a. DATE OF DEATH MONTH DAY YEAR 08 07 87		2b. HOUR 4:53 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 07 25		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY City Balto. Police
13a. STATE MD	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1508 DOVER CT 21061	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY MARUCCI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELLA Imonica			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 579306729		17. INFORMANT ADDRESS Richard L. Connelly Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) PNEUMONIA, CEREBROVASCULAR ACCIDENT 2 WEEKS DUE TO, OR AS A CONSEQUENCE OF: (c) METASTATIC MALIGNANT MELANOMA >3 mos.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from JULY 20 19 87 to AUGUST 7 19 87 that (I) (we) last saw the deceased alive on AUGUST 20 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE James M. Klemm MD		DEGREE		22c. DATE SIGNED 8/7/87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES M. KLEMAN		22e. ADDRESS UNMS 22 S. GREENE ST BALTO.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/87	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA Co., Md.
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE John Swindler	

33
38
39
42
49

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low register that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for review, filing, transmission, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediate notification should be notified of police.

BP

005271 AUG 13 83

005271 AUG 13 83

062774 AUG 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22591

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JESSIE W. CONROY			2a. DATE OF DEATH MONTH DAY YEAR August 12, 1987		2b. HOUR a 9:30 M								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1893		6. AGE (IN YEARS, LAST BIRTHDAY) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 401 E. Cold Spring Ln. 21212				
14. FATHER'S NAME FIRST MIDDLE LAST John Whalley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 20 4894			17. INFORMANT ADDRESS Mrs. Donna Manuel, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Severe Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>10 yrs</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u>													
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET —		CITY OR TOWN —		COUNTY —		STATE —			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>86</u> , to <u>8/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, in (we) (did) (do not) view the body after death.													
22b. SIGNATURE <u>Gregory J. Walker MD</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gregory Walker, MD				22e. ADDRESS Calvert & 33rd Sts., Balto., MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/13/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN Balto.,		COUNTY MD		STATE MD			
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co.										25. DATE RECEIVED BY REGISTRAR AUG 15 1987		26. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

BP

085554 AUG 14 81

AUG 12 1981

064802 SEP -4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22592

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST
GEORGE W CONWAY JR
2a. DATE OF DEATH MONTH DAY YEAR
8/31/87
2b. HOUR
9-15A.M.

3. SEX M 4. RACE B 2 5. DATE OF BIRTH MONTH DAY YEAR
11 13 31
6. AGE (IN YEARS LAST BIRTHDAY) 55
7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto md
7b. CITIZEN OF WHAT COUNTRY? N.S.A
8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH C.R. MD

10. CITY OR TOWN OF DEATH Baltimore
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LMC 2600 Liberty Ave
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE md 13b. COUNTY 13c. CITY OR TOWN Balto
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE 3407 Woodbrook Ave 21217

14. FATHER'S NAME FIRST MIDDLE LAST
George W Conway Sr
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Martha ANN. L. Oswell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
16b. SOCIAL SECURITY NO. 217-264347
17. INFORMANT ADDRESS 3407 apt 12 21217
VALERIE M. CONWAY WOODBROOK AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastasis Carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a. I certify that (I) (this hospital) attended the deceased from 8/26/87, 1987, to 8/31/87, 1987, that (I) (we) last saw the deceased alive on 8/31/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE R.M. Shah M.D. DEGREE 22c. DATE SIGNED 8/31/87.
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH. 22e. ADDRESS LIBERTY Medical Center 2200 LIBERTY HT AVE, BAL. MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B 23b. DATE 9/5/87 23c. NAME OF CEMETERY OR CREMATORY Woodlawn C. 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Joseph C. Rurr 2222 W York St SEP 3 1987 Julia Tindon-Rudner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

76-4-932 S O 9 4 20

76-4-932 S O 9 4 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 22593	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST COOK, DWAYNE A.						2a. DATE OF DEATH MONTH DAY YEAR 8/28/87			2b. HOUR 11:20 AM		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 1 57		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
2b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 626 Wicklow Rd. 21229			
14. FATHER'S NAME FIRST MIDDLE LAST NOAH COOK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVIA KENSLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN				16b. SOCIAL SECURITY NO. 216-62-1948		17. INFORMANT ADDRESS OLIVIA McFadden 626 Wicklow Rd 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADVANCED LIVER FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRRHOTIC LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ALCOHOLISM</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Grav. resp. failure and Renal Failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-26-87 to 8-28-87, that (I) (we) last saw the deceased alive on 8-28-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. J. A. J.						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AJAIA SIMONE						22e. ADDRESS 5000 Delb. Crk. Pike Delb 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-2-87		23c. NAME OF CEMETERY OR CREMATORY ARBUTHUS MEMORIAL PK			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY, MD.			
24. FUNERAL DIRECTOR NAME NUTTER FUNERAL HOMES INC.						25a. DATE REC'D. BY REGISTRAR 8-30-87					
ADDRESS 2501 Gwynns Falls Pk						25b. REGISTRAR'S SIGNATURE John Davidson					

BP

081510 SEP-40

3

SEP03 1940

Items, 18a., 21a.-22a., G-631, by Med. Ex. **STATE OF MARYLAND**
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 5 9 4
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
James S. Coolahan								ESTIMATED		8		30		19		87					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		White		Oct 19 1948		38						8		30		19		87		7:50 P.M.	
2b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland				U.S.A.								Baltimore City MD									
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore				1713 W. Lombard St.				Carpenter				Construction									
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
Maryland				Baltimore				xx				1918 West Lombard St. 21223									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT					
John T. Coolahan Sr				Lillian M. Stauffer				Yes Viet Nam 215-46-6556				Shirley Coolahan 714 East Fort Ave									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute narcotic intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 30 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject used drugs													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1713 W. Lombard Street, Baltimore, Maryland													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> .																					
ACTUAL SIGNATURE <u>Margareta Ore Kule</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 8-31-87									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/4/87				23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto Md									
24. FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hgwy Balto Md				25a. DATE REC'D. BY REGISTRAR SEP02 1987				25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR THE CHIEF MEDICAL EXAMINER. WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, CREMATION, OR REMOVAL RECORD. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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UNITED STATES
NAVY



SEP03 1947

064803 SEP-4-87

Items 12a, 12b, 17 Film G631

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22595

REG. NO.

FOR
1- STATE 9-4-87, LJ
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Melvin R. Cooley			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8/ 29/ 19 87			7b. HOUR M 8:26 A		
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 1 60	6. AGE (IN YEARS) (LAST BIRTHDAY) 27 YRS.	IF UNDER 1 YR. MONTHS DAYS 27	IF UNDER 24 HRS. HOURS MIN 27	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8/ 29/ 19 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 736 BARTLETT AVENUE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EMPLOYED		
13a. STATE MD			13b. COUNTY BALTO.			13c. CITY OR TOWN BALTO.		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD COOLEY, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA INGRAM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-84-6554			17. INFORMANT NAME ADDRESS Cooley Cliftwood ANNA INGRAM 2040 CLIFTVIEW AVENUE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/ 29/ 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bathroom at		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 736 Barlett Ave., Baltimore City, Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>[Signature]</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 8/29/87		
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/4/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME WM. C MARCH F/H, INC.			ADDRESS 1101 E. NORTH AVE.			25a. DATE REC'D. BY REGISTRAR SEP 3 1987		
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMM - 17
(VR A15 ME (15))

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DMD

WILLIAMS



Handwritten signature or initials.

1988 208400

062630 AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22596

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
ALTHEA F. S. CORNISH		8 06 87			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	BLACK	MONTH DAY YEAR 4 07 1915		72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	U. S. A.			BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	1916 DRUID HILL AVENUE		SECRETARY-HOSTESS		MORGAN STATE UNIV.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND		BALTIMORE	13e. STREET ADDRESS / ZIP CODE		
			BALTIMORE, MD. 1916 DRUID HILL AVENUE 21217		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST JOSEPH WILLIAM SAUNDERS		FIRST MIDDLE LAST MARQUERITE MACBETH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		212-38-0181		MR. BALTIMORE, MARYLAND HOWARD CORNISH 1923 DRUID HILL AVE. 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>extensive metastatic hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>extensive metastatic colon carcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>7/24</u> 19 <u>85</u> to <u>8/6</u> 19 <u>85</u> that (I) (we) saw the deceased alive on <u>7/24</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>H. B. Grochow MD</u> DEGREE				22c. DATE SIGNED <u>8/10/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. B. Grochow</u>				22e. ADDRESS <u>600 N Wolfe St.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/11/1987		ARBUTUS MEMORIAL PARK	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
BALTIMORE, MARYLAND					
24. FUNERAL HOME, INC. ADDRESS				25a. DATE REC'D. BY REGISTRAR	
2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216				AUG 12 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

061751 AUG

587 OR
STATE
- REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22597

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EFFINGER D. COSNER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 1, 1987		2b. HOUR 2:20 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cutter,		12b. KIND OF BUSINESS OR INDUSTRY B.G.&L.
13a. STATE Maryland		13b. COUNTY -----	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob ----- Cosner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle ----- Hartman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-26-3637		17. INFORMANT ADDRESS Mrs. Edith M. Cosner, Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>acidosis, hypoxia, RBBB</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 day</u> <u>3 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>large cell lymphoma - Richter's syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> 19 <u>87</u> to <u>8/1</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mark H. Hays</u>				22c. DATE SIGNED 8/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mark H. Hays</u>				22e. ADDRESS <u>Johns Hopkins Balto Md</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Storm Cemetery	
23d. LOCATION Mt. Storm Grant Co. W. Va.		23e. DATE REC'D. BY REGISTRAR AUG 4 1987			
24. FUNERAL DIRECTOR Balto. Md. 21230 McCurly Funeral Home, 130 E. Fort Ave.		25b. REGISTRAR'S SIGNATURE Julia Swinton-Rendall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. The funeral director should be notified by the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

081521 AUG-28

7 5 2 6 4

062615 AUG 13 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22598
2a DATE OF DEATH MONTH DAY YEAR 8 7 87 2b HOUR M1 - FOR
STATE
REGISTRAR3a DECEASED NAME FIRST MIDDLE LAST
SHERMAN L. COTTMAN3. SEX
MALE4. RACE
BLACK5. DATE OF BIRTH
MONTH DAY YEAR
5 19 416 AGE (IN YEARS LAST BIRTHDAY)
46IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD7b CITIZEN OF WHAT COUNTRY?
U.S.A.8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD.10 CITY OR TOWN OF DEATH
BALTIMORE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1702 WADSWORTH WAY12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A12b KIND OF BUSINESS OR INDUSTRY
N/A13a STATE
MD13b COUNTY
BALTO.13c CITY OR TOWN
BALTO.13d INSIDE CITY LIMITS?
YES ☒ NO ☐
13e STREET ADDRESS / ZIP CODE
1702 WADSWORTH WAY 2123914 FATHER'S NAME
FIRST MIDDLE LAST
JULIUS15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARJORIE JOHNSON16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO16b SOCIAL SECURITY NO.
220-34-946417 INFORMANT ADDRESS
KARYN COTTMAN 1702 WADSWORTH WAY18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acquired Immunodeficiency Syndrome 6 months
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Human Immunodeficiency Syndrome 2 years
DUE TO, OR AS A CONSEQUENCE OF
(c)PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Toxoplasmosis encephalitis19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED
20a AUTOPSY?
YES ☐ NO ☐
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 38 PART 1 OR PART 2)
21d INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f LOCATION
STREET CITY OR TOWN COUNTY STATE22a I certify that (1) this hospital attended the deceased from MARCH 2, 1987, to August 7, 1987 that (1) (we) lost June 15, 1987, and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.22b SIGNATURE
Priscilla A. Furth MD
DEGREE
22c DATE SIGNED
8-11-8722d PHYSICIAN'S NAME (TYPE OR PRINT)
PRISCILLA A. FURTH
22e ADDRESS
806243 UMH
22S. GREENE ST BALTIMORE, MD 2120123a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL
23b DATE
8/12/87
23c NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY
23d LOCATION
CITY OR TOWN COUNTY STATE
ANNE ARUNDEL CO., MD24 FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.
25a DATE REC'D. BY REGISTRAR
AUG 11 1987
25b REGISTRAR'S SIGNATURE
L. L. DavidsonTO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

065812 and 1381

Attention is directed to the fact that the
above information is for information only and
should not be used for any other purpose.

FB 11-5

am.

2000

On 11/11/58

For the information of the Bureau, the following information is being furnished:

Reference is made to the letterhead memorandum dated 11/11/58.


064702 SEP-3-87


FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22599
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEANNETTE F. COWLEY			2a. DATE OF DEATH MONTH DAY YEAR 8 27 87			2b. HOUR 11:03 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 13 13		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home Maker	
13a. STATE MD				13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 413 AUDREY AVENUE 21225			
14. FATHER'S NAME FIRST MIDDLE LAST John			15. MOTHER'S MAIDEN NAME ST. MIDDLE LAST Anna O'Neil						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WHAT STATE) 217-26-0281		17. INFORMANT ADDRESS Angela R. Johnston Same as 13c					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE COPD.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 8/17/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED ULCER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/27 1987 to 8/27 1987, that (I) (we) last saw the deceased alive on 8/27 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE 				DEGREE MD		22c. DATE SIGNED 8/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. KLEIN				22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md	
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR SEP 02 1987		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

084705 29-387

SEP 03 1995

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22600
REG. NO.

1. DECEASED NAME (Type or print) FIRST MIDDLE LAST MARY KATHERINE BEASLEY COX			2a. DATE OF DEATH MONTH DAY YEAR 8 12 87 2b. HOUR M		
3 SEX FEMALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 28 17		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10 CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1623 N. Broadway			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) N/A	
12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. STATE MD					
13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1623 N. BROADWAY 21213					
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. GOODALL			15. MOTHER'S MAIDEN NAME MIDDLE LAST GERTRUDE WOODS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-09-4438		17 INFORMANT ADDRESS CLARA COX 3110 FEDERAL STREET	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>7/15</u> 19 <u>87</u> , to <u>7/15</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>7/15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Earl Hope</u>		DEGREE MD		22c. DATE SIGNED 8/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Earl Hope		22e. ADDRESS Johns Hopkins Hospital, Balto MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/18/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT'L CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD		24 FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H 1101 E. NORTH AVENUE			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

AUG 17 1987 REGISTRAR'S SIGNATURE

003100 AUG 1981



003100 AUG 1981



061968 AUG -87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22601

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
William D. Cox JR.						8-1-87			19			M							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH DAY YEAR			2d. HOUR									
M	B	6 25 67	20 YRS.			8-1-87	19			12:13a									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH							
MD			U.S.A.			WIDOWED			DIVORCED			Baltimore City MD							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Baltimore			507 N. Collington Avenue			MOVER			N/A										
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD														BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1720 ABBOTSTON STREET 21218	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
WILLIAM D. COX SR.						GEORGIA MCCORKEL													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
NO						214-86-1785						GEORGIA MORROW 1720 ABBOTSTON STREET							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Stab wound of chest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

? 7-31-87 YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject stabbed during an altercation

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

house

21f. LOCATION

507 N. Collington Avenue Baltimore, Maryland

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Dennis F. Smith
TITLE (SPECIFY)
Assistant MEDICAL EXAMINER

DATE SIGNED 8-1-87

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smith, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/7/87

23c. NAME OF CEMETERY OR CREMATORY

KING MEMORIAL PARK

23d. LOCATION (CITY OR TOWN)

RANDALLSTOWN,

COUNTY

STATE MD

24. FUNERAL DIRECTOR

WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

AUG 06 1987 *Julia Davidson-Randall*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE KEPT AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))

081008 AUG-88



RECEIVED

MAINTENANCE

081008 AUG-88

062286 AUG 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 0 0 2

1. DECEASED NAME (TYPE OR PRINT) John J. Crocamo			2a. DATE OF DEATH MONTH DAY YEAR 8 8 87		2b. HOUR 2:42 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1934	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12. CITY OR TOWN OF DEATH BALTIMORE	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY HOSP		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland	16b. COUNTY Baltimore	16c. CITY OR TOWN Baltimore	16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	16e. STREET ADDRESS / ZIP CODE 2753 Maryland Avenue 21218	
17. FATHER'S NAME FIRST MIDDLE LAST Joseph Crocamo	18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elvira Fusco		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
20. SOCIAL SECURITY NO. 213-30-8470		21. INFORMANT ADDRESS Letizia Crocamo 2753 Maryland Ave. 21218			
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
23. DATE OF OPERATION 19a.		24. CONDITION FOR WHICH OPERATION WAS PERFORMED 19b.		25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		31. LOCATION STREET CITY OR TOWN COUNTY STATE	
32. I certify that (I) (this hospital) attended the deceased from <u>7-23-87</u> , 19 <u>87</u> , to <u>8-8</u> , 19 <u>87</u> ; that (I) (we) lost saw the deceased alive on <u>8-8</u> , 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
33. SIGNATURE <u>[Signature]</u>		34. DEGREE MD		35. DATE SIGNED 8-8-87	
36. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LEFF</u>		37. ADDRESS <u>FSK HOSPITAL EASTERN AVE BALTO. MD</u>			
38. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	39. DATE Aug 11 1987	40. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		41. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
42. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		43. DATE REC'D. BY REGISTRAR AUG 10 1987		44. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there was any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

002288 AUG 11 67

22	Sept. 11, 1967	White	Male
XX		U.S.A.	Foreign
Shaded			
2505 Maryland Avenue, N.W.	Washington, D.C.	Washington, D.C.	Washington, D.C.
Place	State	City	Country
2505 Maryland Ave., N.W.	Washington, D.C.	Washington, D.C.	Washington, D.C.

August 10, 1967
Washington, D.C.
Washington, D.C.
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma to the body, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2260-3

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
3. DECEASED NAME (Type or Print)		4. RACE		5. DATE OF BIRTH	
ALAN G. CROSS		White		March 15, 1923	
6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
64 YRS		Illinois		U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Baltimore City, MD		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Union Memorial Hospital		Ret. - Baltimore City Police			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland				Baltimore	
14. FATHER'S NAME (Type or Print)		15. MOTHER'S MAIDEN NAME (Type or Print)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Lincoln Cross		Mary Twigg		Yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>malignant pericardial effusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cut Lung</u>	
337-14-9163		Mrs. Phyllis E. Cross Same as #13c		Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>LT</u> (b) <u>RT</u> (c) <u>LA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-17</u> , 19 <u>87</u> , to <u>8-2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. ADDRESS		22d. DATE SIGNED	
<u>George E. Lowe</u>		3703 Belair Rd.		8-9-87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		22g. DATE REC'D. BY REGISTRAR	
George E. Lowe, M.D.		3703 Belair Rd.		Aug 10 1987	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-5-87		Parkwood	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF CEMETERY OR CREMATORY		23f. DATE REC'D. BY REGISTRAR	
Baltimore, Maryland		Parkwood		Aug 10 1987	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
Leonard J. Ruck, Inc.		Baltimore, Maryland		Aug 10 1987	

MEDICAL CERTIFICATION

062957 AUG 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 6 0 4

REG. NO.

FOR
1. STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

HELEN

B

CROSS

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P M
AUGUST 13, 1987 8:20 P M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

May 28, 1919

6. AGE (IN YEARS LAST BIRTHDAY)

68

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Dispatcher.

12b. KIND OF BUSINESS OR INDUSTRY

Airlines

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

21234

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

4461 Wycombe Way 21234

14. FATHER'S NAME

Charles

MIDDLE

H.

LAST

Cross

15. MOTHER'S MAIDEN NAME

Florence

MIDDLE

I.

LAST

Pocock

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

204-01-0460

17. INFORMANT

Philip K. Cross 4534 Perkins Ct. 21017

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio respiratory Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

0 min

DUE TO, OR AS A CONSEQUENCE OF

Sepsis

2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

Colon Cancer

5 months

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Cerebrovascular Accident, small bowel obstruction

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 13 Aug 1987 to 13 Aug 1987, that (I) (we) last saw the deceased alive on 13 Aug 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/13/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

BENJAMIN YOKEL MD

22e. ADDRESS

606 N. Wolfe St. Johns Hopkins Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

AUG. 17, '87

23c. NAME OF CEMETERY OR CREMATORY

MT. ZION CHURCH

23d. LOCATION

FREELAND, MARYLAND

COUNTY

STATE

24. FUNERAL DIRECTOR

WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.

25a. DATE REC'D. BY REGISTRAR

AUG 14 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is valid for 24 hours after death. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must file a report of death.

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E84P DSS 8

064729 SEP 4 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22605
22605
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES GILBERT CROSS			2a. DATE OF DEATH MONTH DAY YEAR 8-14-87		2b. HOUR 7:08 PM
3. SEX M	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 07/16/1919		6. AGE (IN YEARS LAST BIRTHDAY) 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING
13a. STATE MD		13b. COUNTY Balt.	13c. CITY OR TOWN Catonville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD MARSHALL CROSS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABELLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II		16b. SOCIAL SECURITY NO. 215073989		17. INFORMANT JAMES G. CROSS, JR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory & body failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) squamous cell lung ca.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-21 19 84 , to 8-14 19 84 , that (I) (we) last saw the deceased alive on 8-14 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]				22c. DATE SIGNED 8-14-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Haugh				22e. ADDRESS 900 Caton Ave. Balt.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 16 August 87		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonville Balt. Md.		23e. DATE REC'D. BY REGISTRAR SEP 03 1987			
24. FUNERAL DIRECTOR NAME Black Funeral Home		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

(IMPORTANT: If item 21 is marked as item 1B above any injury or other traumatic event, the medical examiner will be notified at once.)

BP

084552 SEP-4-81

20855



1057

SEP02

064177 AUG 3 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22000

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JESSE CROWDER, JR			2a DATE OF DEATH MONTH DAY YEAR 8 24 1987		2b HOUR M
3 SEX male	4 RACE black	5 DATE OF BIRTH MONTH DAY YEAR 9 1 1928		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1636 Thomas Avenue		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) A.A.A.		12b KIND OF BUSINESS OR INDUSTRY A.A.A.
13a STATE Md		13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Jesse Crowder, Sr		15 MOTHER'S MAIDEN NAME FIRST MIDDLE Betty Hester			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 243-40-7883	17 INFORMANT ADDRESS Minnie A. Crowder 1636 Thomas Avenue		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1986, 1987, to 1987, 1987, that (I) (we) lost saw the deceased alive on JULY 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard M. Hunt		DEGREE MD		22c. DATE SIGNED 8-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard M. Hunt		22e. ADDRESS 2300 Garmson Blvd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/29/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arundel Co Md
24 FUNERAL DIRECTOR NAME Win. C. March F/H		ADDRESS West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR AUG 27 1987	
		25b. REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and legally filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

064155 WGS 31 01

WGS 31 01

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 2 6 0 7

REG. NO.

063509

1. FOR
STATE
REGISTRAR

AUG 24 87

2. DATE OF DEATH MONTH DAY YEAR 8-20-87 7:16 AM

3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 8-19-87 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. 0 MONTHS 0 DAYS 16 HRS. MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -- 12b. KIND OF BUSINESS OR INDUSTRY --

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY -- 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 3709 Falls Road 21211

14. FATHER'S NAME FIRST MIDDLE LAST Timothy Crowther 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melissa Crowther Condon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -- (IF YES, GIVE WAR OR DATES) -- 16b. SOCIAL SECURITY NO. -- 17. INFORMANT ADDRESS Bunny Wiles 3709 Falls Road 21211

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiorespiratory failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) prematurity (extreme)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8-20-87 to 8-20-87, that (I) (we) last saw the deceased alive on 8-20-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.

22b. SIGNATURE Adeline D. 22c. DATE SIGNED 8-20-87 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Antonie Kline 22e. ADDRESS Sinai Hospital Baltimore, MD 21215

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8/24/87 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore (Hampden) Maryland

24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211 25a. DATE REC'D. BY REGISTRAR AUG 21 1987 25b. REGISTRAR'S SIGNATURE Julia Dinkon-Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

003202 WGS 54 03

WGS 54 03

062322 AUG

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22608

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
John			T.			Crump SR.			8 4 1987			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
M		B		5 12 43		44 YRS.		MONTHS DAYS		HOURS MIN.		8 4 1987		3:40P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH			
MD				U.S.A.				WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore City MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				3120 E. Federal Street				UNEMPLOYED				N/A			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD						BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3120 E. FEDERAL STREET 21213					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
JOHN W. TAYLOR				MARY CRUMP											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
YES				219-38-8098				ETHEL M. CRUMP 819 E. 41st STREET							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Chronic alcoholism</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?															
HEAD & ABD. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Mario F. Golle, Jr., M.D.				M.D. Assistant MEDICAL EXAMINER				8/5/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Mario F. Golle, Jr., M.D.				111 Penn St. Balto, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				8/10/87		GARRISON FOREST				OWINGS MILLS, MD					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
WM. C. MARCH F/H, INC.				1101 E. NORTH AVE.				AUG 7 1987				Julia Henderson			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))

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AUG 11 87
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH7 2 2 6 0 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LORETTA ANN CUFFLEY			2a. DATE OF DEATH MONTH DAY YEAR 08/04/1987		2b. HOUR 0145AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 06/29/43		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2538 FREDERICK ROAD 21228
14. FATHER'S NAME FIRST MIDDLE LAST JOHN F. COLVIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-38-7189		17. INFORMANT ADDRESS EDWARD L. CUFFLEY 2538 FREDERICK RD. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Colon Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>11/13/85</u> , 19____, to <u>8/4/87</u> , 19____, that (I) (we) last saw the deceased alive on <u>6/22/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22a. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/4/87</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Gormley</u>		22e. ADDRESS <u>900 CATON AVE BALD. MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/7/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229			25a. DATE REC'D. BY REGISTRAR AUG 07 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or organ donation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22610

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HORACE CURRY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 17, 1987		2b. HOUR 11:07pm		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 12 11		6. AGE (IN YEARS/LAST BIRTHDAY) 76 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY B&O RAILROAD	
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT CURRY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY		13e. STREET ADDRESS / ZIP CODE 2017 BURNWOOD RD 21239			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-10-7470		17. INFORMANT ADDRESS MARY A. RAGLAND 2017 BURNWOOD RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: SEPSIS IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: STATUS POST LEFT SIDED CARDIOVASCULAR ACCIDENT							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from JUNE 9, 1987 to AUGUST 17, 1987 , that (X) (we) last saw the deceased alive on AUGUST 17, 1987 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (X) (we) did not view the body after death.							
22b. SIGNATURE Karl F. Love, MD				DEGREE MD		22c. DATE SIGNED 8/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karl F. Love, MD				22e. ADDRESS c/o MARYLAND GENERAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/21/87		23c. NAME OF CEMETERY OR CREMATORY MD NAT'L MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL, MD	
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.				25. DATE REC'D. BY REGISTRAR AUG 20 1987		26. REGISTRAR'S SIGNATURE Julia Henderson-Rudolph	

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100-111-4-11623

063412 AUG 21 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22611

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES CURTIS			2a. DATE OF DEATH MONTH DAY YEAR 8/14/87		2b. HOUR 9²⁰ AM
3. SEX MALE	4. RACE NEGROID	5. DATE OF BIRTH MONTH DAY YEAR 9-2-32		6. AGE (IN YEARS LAST BIRTHDAY) 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		10. CITY OR TOWN OF DEATH Balto.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cent.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1720 Durham St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST unk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. unk		17. INFORMANT ADDRESS EDNA SPEARMAN 1501 E. Lafayette Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe illness DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/29 19 81 , to 8/14 19 87 , that (I/we) <input checked="" type="checkbox"/> saw the deceased alive on 8/14 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 8-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett		22e. ADDRESS Francis Scott Key Med. Cent.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-22-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.					
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs		ADDRESS 1412 E. Preston		25a. DATE RECD. BY REGISTRAR AUG 20 1987	
25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, a medical examiner must be notified of the death.

BP

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063186 AUG 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

22612

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH OLLIE CURTIS			2a. DATE OF DEATH MONTH DAY YEAR 8 12 87		2b. HOUR M M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 4 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1324 WEST LANVALE STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ROGER MOLDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY L CURTIS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-09-0189		17. INFORMANT ADDRESS CHART		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) metabolic abnormality 2° chronic renal failure unknown DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): hypertension, diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Lucille W. King		DEGREE		22c. DATE SIGNED 8/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lucille W. King		22e. ADDRESS Wyman Park Med Ctr, 3100 Wyman Pk Dr, Balt., MD 21211				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-17-87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VET.		
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS		ADDRESS 1721 NORTH MONROE STREET		25a. DATE REC'D. BY REGISTRAR AUG 18 1987		
		25b. REGISTRAR'S SIGNATURE Richard B. [Signature]				

MEDICAL CERTIFICATION

2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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064058 AUG 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22613
22613
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS J. DALESANDRO JR.			2a. DATE OF DEATH MONTH DAY YEAR 8/23/87		2b. HOUR 4:35 A.M.	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8/1/1903	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS D'ALESSANDRO SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANTOINETTE FLOPPIANO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-20-9368		17. INFORMANT ADDRESS NANCY D'ALESSANDRO 245 ALBEMARLE ST 21202		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Patulous aortic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> , 19 <u>87</u> , to <u>8/23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHENG				22e. ADDRESS 14711 VALIANT TERR BARTONVILLE MD 20862		
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 8/26/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.
24. FUNERAL DIRECTOR NAME Donald P. [Signature]				25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE Julia [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and return them to the funeral director. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

064028 82-011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRS 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 6 1 4

FOR
STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard II Dalmaso			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1987		2b. HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Franklin, Penna.	7b CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Balto City Fire Dep		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland	13b COUNTY -	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 3402 Seneca Street (21211)	
14. FATHER'S NAME FIRST MIDDLE LAST Angelo Dalmaso		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Orsiga			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea	17. INFORMANT ADDRESS Evelyn Dalmaso-3402 Seneca St. 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>17 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>19 70</u> to <u>8-29</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8-29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Laurens Solomon MD</u>	DEGREE MD			22c DATE SIGNED 8/12/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Laurens Solomon MD	22e ADDRESS 400 Old Court Rd 21208				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 8/11/87	23c NAME OF CEMETERY OR CREMATORY Sherwood Episcopal Ch	23d LOCATION CITY OR TOWN COUNTY STATE Cem. Cockeysville, Md.		
24 FUNERAL DIRECTOR A. Alan Seitz- 3818 Roland Avenue		25a DATE REC'D BY REGISTRAR AUG 10 1987		25b REGISTRAR'S SIGNATURE Alicia Terison-Randall	

MEDICAL CERTIFICATION

185331 AUG 11 85

8/11/85

Burial



063584 AUG 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATHREG. NO. 22615
DATE OF DEATH 8 19 1987
HOUR 1:19A

1. DECEASED NAME (TYPE OR PRINT) Clifton Darby		2a. DATE OF DEATH 8 19 1987		2b. HOUR 1:19A	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 4 9 62	6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 901 Cator Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCY	
13a. STATE MD		13b. COUNTY BALTO.		13c. STREET ADDRESS 901 CATOR AVENUE 21218	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS DARBY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMA FRAZIER DARBY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-78-4396		17. INFORMANT ADDRESS ALMA DARBY 901 CATOR AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:50xx 8 19 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 901 Cator Ave. Balto. MD.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 8/19/87	
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.		ADDRESS 111 Penn St.		BALTO. MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.		ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR AUG 21 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Smith</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PLACES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

03284 100 32 01

55012

53-11 NOTOD 3002



WMA



1001 1830A

064052 AUG 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22616

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES Edward DAUM			2a. DATE OF DEATH MONTH DAY YEAR 8 25 87		2b. HOUR 6:30 A.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 15 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pridemark Custom		12b. KIND OF BUSINESS OR INDUSTRY Homes			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 301 German Hill Road 21222			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Daum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frieda Kratz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-09-3618A		17. INFORMANT ADDRESS Norma E. Daum 301 German Hill Road 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) METASTATIC Cancer DUE TO, OR AS A CONSEQUENCE OF } (c) PROSTATE Cancer											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/25 19 87 , to 8/25 19 87 , that (I) (we) last saw the deceased alive on 8/25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE Arthur M. Sieper				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR M. Sieper				22e. ADDRESS SINAI Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-26-87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				DATE REC'D BY REGISTRAR AUG 27 1987							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

X

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 2 2 6 1 7
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST Fannie L. Davenport			2a. DATE OF DEATH MONTH DAY YEAR 8/31/87		2b. HOUR M		
3 SEX F		4 RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 5 8 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2016 Harlem Avenue		12a. USUAL OCCUPATION / (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ned Coleman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Johnson		13e. STREET ADDRESS / ZIP CODE 2016 Harlem Avenue 21217			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 220 30 1493A		17. INFORMANT ADDRESS James Davenport 2016 Harlem Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Atherosclerotic heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 15 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>86</u> , to <u>August</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/3</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE <u>Mark Schlissel</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK Schlissel MD		22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 4, 1987		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons		ADDRESS 1701 Laurens St.		25a. DATE REC'D. BY REGISTRAR SEP 01 1987			
				25b. REGISTRAR'S SIGNATURE <u>Julia Burdon-Randall</u>			

Medical examiner must be notified of one.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic result, the medical examiner must be notified of one.

BP

084001 SEP-58

SEP 01 1958

064301 SEP 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22618

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
		Louis A. Davenport Jr.					X	8	24	19 87	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
M	B 2	11 27 32	54 YRS.			8 24 19 87				5:36 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore MD	USA			Baltimore City MD							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore	4016 Fairfax Ave. N		MAINTENANCE								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS							
MD		Baltimore		4016 Fairfax Rd 21216							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Louis A Davenport		Dorothy Davenport		3806 Woodbine Ave							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
W		212-30-4092		HARRINGTON		C.O.N.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Alcoholism</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Mario F. Golle, Jr.		M.D. Assistant		8-25-87							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Mario F. Golle, Jr., M.D.		111 Penn St., Balto., MD		21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial	8-1-87	Mt Auburn		Baltimore, MD, 21230							
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Marshall D. Hayes 4350 Gilman St		AUG 31 1987		John Davenport							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

062518 AUG 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 2 5 1 9 REG. NO.			
1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		Edna				Davis		DATE ESTIMATED		8	4	1987	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		7d. HOUR	
FEMALE	WHITE	JUNE 15, 1909		78 YRS.						8		12:48 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA		WIDOWED		DIVORCED		Baltimore City		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Maryland General Hospital		SALESLADY		RETAIL							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		APT. 210			
MARYLAND				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5715 PARK HTS. AVE.		21215			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
JOSEPH		DAVIS		NECHAMA		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		APT. 804							
NO		216-01-2674		AARON MILLER		6210 PARK HTS. AVE. BALTO., MD 21215							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION									
				CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, and in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Mario F. Golle, Jr.		Assistant		8/5/87									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Mario F. Golle, Jr., M.D.		111 Penn St. Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
BURIAL		AUG. 7, 1987		BETH HAMEDROSH HAGODOL		ROSEDALE		BALTO.		MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
SOL LEVINSON & BROS., INC.		AUG 12 1987		Julia Davidson-Randall									
6010 REISTERSTOWN RD. BALTO., MD 21215													

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WARRIOR

064061 AUG 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87
REG. NO.22620
10:30a.

1. DECEASED NAME (TYPE OR PRINT) ESTELLE JEAN DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 8 24 87		2b. HOUR 10:30a.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 22 04		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD (City) MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Rochowicz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Lukowsky		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 213-05-2234A	
17. INFORMANT Richard P. Davis, 4430 Springwood Avenue Baltimore, Md. 21206		17. ADDRESS		17. ADDRESS		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HEART FAILURE; ATRIAL FIBRILLATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>87</u> , to <u>8/24</u> , 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>8/24</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did not) view the body after death.							
22b. SIGNATURE <i>A. B. Nazemi, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.B. NAZEMI, M.D.				22e. ADDRESS 100 N. Broadway, Balto., MD 2131			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR Ann S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224				25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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063731 AUG 26 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 2 2 6 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) 1. ETHEL		2. AKA : E. HELEN DAVIS		3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 01 DAY 29 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 93		7a. DATE OF DEATH MONTH 08 DAY 21 YEAR 87		7b. HOUR 0430 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 MAPLE AVENUE 21228		14. FATHER'S NAME FIRST MIDDLE LAST CHARLES RENN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA BASSLER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 213-74-7184		17. INFORMANT ADDRESS 21228		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Several days 5 or 6 weeks		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>11 August</u> 19 <u>87</u> to <u>21 August</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>21 August</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <u>Timothy D. Nichols MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/21/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Timothy D. Nichols</u>		22e. ADDRESS <u>6404 D N. Centennial Pl., Glen Burnie, MD 21061</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/24/87	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE. CATONSVILLE MD 21228		25. REC'D. BY REGISTRAR AUG 25 1987		26. REGISTRAR'S SIGNATURE <u>Julia Sanders-Rudolph</u>		27. REGISTRAR'S SIGNATURE		28. REGISTRAR'S SIGNATURE		29. REGISTRAR'S SIGNATURE	

063131 AUG 29 81

CONTACT IN BIRMINGHAM

063131 AUG 29 81

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AUG 13 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22622

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Natalie P. Davis Davis		2a. DATE OF DEATH MONTH DAY YEAR 8-10-87		2b. HOUR 11 ¹⁰ PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12-29-04		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE COUNTRY Poland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. Ct.	
10. CITY OR TOWN OF DEATH Balt. Ct.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason F. Lord NH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Factory
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Eastwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Postek		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-10-7402		17. INFORMANT ADDRESS William D. Davis Sr. 7928 St. Bridget Ln.	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Multiple Decubitus Ulcers</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dehydration, Malnutrition, Alzheimer's D.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> 19 <u>87</u> to <u>8-10</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>8-10</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.					
22b. SIGNATURE <u>Richard Bennett</u> MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett		22e. ADDRESS 4940 Eastern Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-13-87	23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR AUG 12 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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062033 AUG 8 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH22623
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. HOUR		
William M. Davis			8/ 3/ 19 87			8/ 3/ 19 87			4:08			a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YR.	IF UNDER 24 HRS.									
MALE	BLACK	JULY 5, 1965	22 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			US of A			NEVER MARRIED			Baltimore City,			MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			900 Blk. Joplea Ave. (on street)			UNEMPLOYED								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND						BALTIMORE			YES X NO			2915 DENHAM CIRCLE 21225		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
ALVIN			PEARL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			219 76 8782			MRS. PEARL GASQUE			2915 DENHAM CIRCLE					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Gunshot Wound of Neck

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		4:01pm 8/ 3/ 19 87		subject shot	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION	
NOT WHILE AT WORK X		on street		900 Blk. Joplea Ave., Balto. City, Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide X, Undetermined manner.

ACTUAL SIGNATURE Dennis F. Smyth TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER DATE SIGNED 8/3/87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY	23f. STATE
BURIAL	8/8/87	MT. AUBURN CEMETERY	BALTIMORE		MD
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE 21215			AUG 06 1987		

25b. REGISTRAR'S SIGNATURE Julia Benson-Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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UNEMPLOYED

2015 DENIAL CANCELS 51255

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BALTIMORE

BALTIMORE

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BALTIMORE

W. J. BROWN CEMETERY

10/25/86

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OR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 22624

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Dawson			2a. DATE OF DEATH MONTH DAY YEAR 08 14 87		2b. HOUR 11:50 PM						
3. SEX M		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 10 11 14		6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS		7. UNDER 1 YEAR MONTHS DAYS 0 0		8. UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WARRENTON, GA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNITED IORN		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2703 Oswego Ave 21215			
14. FATHER'S NAME FIRST MIDDLE LAST COLUMBUS DAWSON				15. MOTHER'S MAIDEN NAME FIRST LAST HATTIE DAWSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 099201608		17. INFORMANT ADDRESS MABLE K. DAWSON 4502 PIMILICO RD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Embolism										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sepsis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from August 14 , 19 87 , to August 14 , 19 87 that (I) (we) lost saw the deceased alive on August 14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert K. Noly				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/19/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILL, MD.					
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIBERTY HEIGHTS				25a. DATE REC'D. BY REGISTRAR AUG 18 1987		25b. REGISTRAR'S SIGNATURE John Davidson					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it goes into the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

BP

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UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250

[Faint, mostly illegible text, likely a memorandum or report, spanning the main body of the page.]

AUG 18 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 and fill with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. A medical examiner must be notified in advance.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified in advance.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22625

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EMMA KING DAY			2a. DATE OF DEATH MONTH DAY YEAR 8 10 87			2b. HOUR 10:32 P.M.			
3 SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 25 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4601 PALL MALL ROAD 21215	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE H. C. KING				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA PARKER				ADDRESS BALTIMORE, MD. 21201	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 212-32-0369		17. INFORMANT MARGARET LOWERY 1100 BOLTON ST. APT. 1010					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vent. arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emboli??									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN STREET COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/14/87 to 8/10/87 , that (I) (we) last saw the deceased alive on 8/10/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE Vazquez						DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VAZQUEZ						22e. ADDRESS LIBERTY MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/14/1987		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.		
24. FUNERAL HOME NUTTER FUNERAL HOMES, INC.						25a. DATE REC'D BY REGISTRAR AUG 21 1987			
25b. ADDRESS 2501 GWYNNS FALLS PKWY. BALTO, MD. 21216						25c. REGISTRAR'S SIGNATURE [Signature]			

063055 AUG 22 81

Abstract

064546 SEP 1-287

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 6 2 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Keith S. Day			2a. DATE OF DEATH MONTH DAY YEAR 8 27 1987			2b. HOUR M			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 11 23 1956		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4104 Liberty Heights Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md			13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 4104 Liberty Heights Ave 21207				
14. FATHER'S NAME FIRST MIDDLE LAST Theodore B. Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris A. Merritt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 217-66-4456		17. INFORMANT ADDRESS Sherry Byrd 2404 Winchester Apt P				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Disseminated Cryptococcal Disease DUE TO, OR AS A CONSEQUENCE OF (b) Acquired Immunodeficiency Syndrome DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2/15/87 2/15/87
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1g

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the physician) attended the deceased from 2/15 19 87, to 8/27 19 87, that (I) (we) last saw the deceased alive on July 24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE John W. Warren, M.D.				DEGREE M.D.		22c. DATE SIGNED 08/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Warren, M.D.				22e. ADDRESS Univ. of MD, 10 S. Pine St. Md 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE Julia D. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the Division of Vital Records, Department of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or any other significant event, the medical examiner must be notified by date.

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062661 AUG 13 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22627
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY W. DECATUR			2a. DATE OF DEATH MONTH DAY YEAR 08 10 87		2b. HOUR 5:00 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 30 35		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Noble L. Decatur, Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia K. Geist		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rigger Handyman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-32-0676		17. INFORMANT ADDRESS Margaret Decatur 804 Wellington St. 21211		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Electromechanical Dissociation DUE TO, OR AS A CONSEQUENCE OF (c) Severe Bradycardia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 mins 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8-10 8-10 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-8 to 8-10 , 19 87 , that (I) (we) last saw the deceased alive on 8-10 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Joseph Raduazzo		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-10-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH RADUAZZO, M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/15/87		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Pk.		
23d. LOCATION (CITY OR TOWN) Sykesville		COUNTY Maryland		STATE		
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.			ADDRESS 3818 Roland Ave. 21211			
25a. DATE REC'D. BY REGISTRAR AUG 12 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

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20% COTTON

WALKER

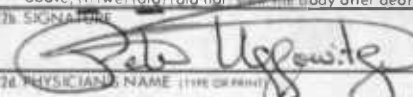
083021 AUG 13 85

061905 AUG-7-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 6 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laraine M. Dennstaedt			2a. DATE OF DEATH MONTH DAY YEAR 8-2-87 2b. HOUR 1945 M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-15-1920	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator	12b. KIND OF BUSINESS OR INDUSTRY Ins. Co.	
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 611 W. 39th St. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Mather		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Beatty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 216-09-2538	17. INFORMANT ADDRESS Lauren Dennstaedt, Same as 13e		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive CVA. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) MI x 5 & probable septal emboli. DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Edema & acidosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 87 , to 8/2 , 19 87 that (I) (we) lost saw the deceased alive on 8/2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE 		DEGREE MD		22c. DATE SIGNED 8-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Uggowitz		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-4-87	23c. NAME OF CEMETERY OR CREMATORY Westview	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral home. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

061302 W6-587

063518 AUG 24 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22629
REG. NO.

1. DECEASED NAME (PRINT) Marie E. Deppish			2a. DATE OF DEATH 8/18/87		2b. HOUR 8:30am	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 6 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MC.			13b. COUNTY Balto.	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lercy Allen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Pfeffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO 214-24-5875		17. INFORMANT ADDRESS Russell Deppish 3520 Dunhaven Road 21222		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Squamous Cell Lung Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>87</u> , to <u>8/18</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Oresky</u>		DEGREE MD		22c. DATE SIGNED 8/18/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oresky		22e. ADDRESS The Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		
24. FUNERAL DIRECTOR NAME Connelly Funeral Home of Dundalk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		25a. DATE REC'D. BY REGISTRAR AUG 21 1987		
		25b. REGISTRAR'S SIGNATURE <u>Kinder-Rindell</u>				

083218 WNC SP 83

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061514 AUG

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 22030
DATE OF DEATH MONTH DAY YEAR 8/1/87 229 P.M.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna J. DERENCEZ		2a. DATE OF DEATH MONTH DAY YEAR 8/1/87		2b. HOUR 229 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8/26/09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH KROLIKOWSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE HUDAK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-03-9931		17. INFORMANT ADDRESS JEANETTE POLEWSKI 7825 WAYBROOK RD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest		10 min
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Infarction		8 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular occlusion		5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) 19	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/1/87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4940 Eastern Ave BALTIMORE MD	
22a. I certify that (I) (this hospital) attended the deceased from 8/1/87 to 8/1/87 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above.			
22b. SIGNATURE Theodore McKinney		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/1/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore McKinney		22e. ADDRESS 4940 Eastern Ave	

23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL	23b. DATE 8-4-1987	23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD
24. FUNERAL DIRECTOR NAME ADDRESS RAYMOND L. KACZOROWSKI 3525 ELLIOT ST		25. DATE REC'D. BY REGISTRAR 8/3/87	
		26. REGISTRAR'S SIGNATURE Julia J. Anderson-Randall	

RECEIVED
JUL 14 1903
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE
WASHINGTON, D.C.

FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

SUBJECT: [illegible]

[illegible text follows]

063086 AUG 19 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2263
22631

1- STATE FOR REGISTRAR		2- DATE KNOWN OF DEATH		3- MONTH DAY YEAR		4- HOUR	
1- DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2- DATE KNOWN OF DEATH		3- MONTH DAY YEAR	
MICHAEL Joseph De SIMONE				8-16-87		M	
5- SEX	6- RACE	7- DATE OF BIRTH	8- AGE (IN YEARS)	9- IF UNDER 1 YR.	10- IF UNDER 24 HRS.	11- DATE PRONOUNCED DEAD	12- HOUR
Male	White	Aug. 5, 1938	49 YRS.			8-16-87	6:52P
13- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		14- CITIZEN OF WHAT COUNTRY?		15- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		16- BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City MD.	
17- CITY OR TOWN OF DEATH		18- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		19- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		20- KIND OF BUSINESS OR INDUSTRY	
Baltimore		Sinai Hospital		Self - employed		Real Estate	
21- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		22- INSIDE CITY LIMITS?		23- STREET ADDRESS			
13a- STATE Maryland		13b- COUNTY		13c- CITY OR TOWN Baltimore		13d- YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14- FATHER'S NAME		15- MOTHER'S MAIDEN NAME		16- 1620 Bolton Street		21217	
Michael De SIMONE		Mary C. Raimondi					
17a- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b- SOCIAL SECURITY NO.		18- INFORMANT		19- ADDRESS	
No		214-36-9306		Mrs. Helle K. De Simone		same as 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY: <u>Multiple injuries</u>							
IMMEDIATE CAUSE (a) <u>Multiple injuries</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u></u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH							
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6PM P.M. 8-16-87 19							
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto/fixed object							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street							
21f. LOCATION CITY OR TOWN STREET Bellona Ave. W. of Ruxton Ave. Baltimore Co., Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
23a. ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 8-17-87							
23b. EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street							
23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery							
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland							
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
AUG 18 1987 <u>Julia Davidson</u>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH : 17
(VR A15 ME (5))

063088 AUG 19 61

Joseph Simon

1928-1930

U.S.A.

Self - employed

1930-1931

Self - employed

21-2-1930



Handwritten notes and markings on the left margin.

Simon, Joseph

Simon, Joseph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified of cause.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 6 3 2
REG. NO.

1. STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE OF DEATH		HOUR	
WILHEMINA C. DEWEY		8 16 87		4 49 PM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	June 15, 1900	87	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Florida	U.S.A.		BALTIMORE CITY MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE CITY	Liberty Medical Center	Cashier	Amusement Park		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Overlea	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7002 Belair Rd. 21206	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Jeptha D. Taylor	Bertha Estelle Glover	16b. SOCIAL SECURITY NO. 214-20-5315			
17. INFORMANT		17 ADDRESS			
Robert T. Dewey, 5909 Cedonia Ave.		21206			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>Sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Pneumonia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-16-87</u> to <u>8-16-87</u> , that (I) (we) last saw the deceased alive on <u>8-16-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Sher A Hashmi</u>		MD		8-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
SHER AFZAL HASHMI		2600 LIBERTY HEIGHTS Ave 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Aug. 19, 1987		Parkwood	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Baltimore		Baltimore		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT C. ALTENBURG FUNERAL HOME, INC.		AUG 18 1987		<u>[Signature]</u>	
6009 Harford Rd., Balto., Md. 21214					

003145 AUG 1985

9

AUG 18 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22633

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BENJAMIN (BEN) DICKLER		2a. DATE OF DEATH MONTH DAY YEAR AUG. 29, 1987		2b. HOUR 2 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC. DAY 1901	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2905 FALLSTAFF RD., APT. 35		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY VENDING MACHINE CO.			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN DICKLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH DICKLER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-7857		17. INFORMANT ADDRESS MITCHELL DICKLER 8415 BELLONA (21204) AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. INJURY OCCURRED CITY OR TOWN COUNTY STATE		21g. LOCATION STREET		21h. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 26, 1987</u> to <u>August 27, 1987</u> , that (I) (we) last saw the deceased <u>alive</u> on <u>August 26, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.					
22b. SIGNATURE <u>R. PERELMERA</u>		DEGREE		22c. DATE SIGNED 8-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. PERELMERA		22e. ADDRESS 5400 OLD COURT RD		22f. DATE REC'D. BY REGISTRAR SEP 4 1987	
22g. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>		22h. REGISTRAR'S SIGNATURE		22i. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-30-87		23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH CONG	
23d. LOCATION CITY OR TOWN BALTIMORE		23e. LOCATION COUNTY BALTIMORE		23f. LOCATION STATE MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		24b. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215		24c. DATE REC'D. BY REGISTRAR SEP 4 1987	

BP

STANDARD FORM NO. 64
MAY 1962 EDITION
GSA GEN. REG. NO. 27

0100 SEP-00

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

064051 AUG 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22634

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHARUN V DIEHL			2a. DATE OF DEATH MONTH DAY YEAR 08 25 87			2b. HOUR 2:45 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Trenton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Knotts				13e. STREET ADDRESS / ZIP CODE 2404 Lodge Farm Road 21219			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-22-5875		17. INFORMANT ADDRESS Donald R. Diehl 2404 Lodge Farm Rd. 21219					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/1/87 , 19 87 , to 8/25 , 19 87 , that (I) (we) lost saw the deceased alive on 8/24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Adlai L. Pappy, MD DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADLAI L. PAPPY, MD						22e. ADDRESS 4940 EASTERN AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk						25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, MD 21222									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial/interment permit. Then please remove carbon papers. Pages 2 and 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

BP

084021 JUL 23 61

U.S. AIR FORCE

2012 12 84

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be filed with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. The certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET E. DIEHL		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10TH, 1987		2b. HOUR 2:47M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1916					
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker & Waitress-		12b. KIND OF BUSINESS OR INDUSTRY Restraunt							
13a. STATE Md.		13b. COUNTY ---		13c. CITY OR TOWN Baltimore					
14. FATHER'S NAME FIRST MIDDLE LAST Fred ---- Buchta		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina ---- Bentz		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ----		16b. SOCIAL SECURITY NO. 217-26-0052		17. INFORMANT Daughter: Mrs. Regina M. Hagert-3428 Mt. Pleasant Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Peritonitis and perforated gastric ulcer</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>87</u> to <u>8/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mark Haigren</u>				22c. DATE SIGNED 8/10					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Haigren				22e. ADDRESS Johns Hopkins Baltimore Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Cemetery-Glen Burnie, Md.					
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home		24b. ADDRESS 3000 E. Baltimore St.; Balto., Md. 21224		25. REGISTRATION BY REGISTRAR Aug 11 1987					

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1. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

64682 SEP-3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1, page 2, and 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

22636

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ELEANOR

DIGGS

2a. DATE OF DEATH MONTH DAY YEAR HOUR

8 24 87 1 M

3. SEX

FEMALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH DAY YEAR
2 26 1900

6. AGE (IN YEARS LAST BIRTHDAY)

87

IF UNDER 1 YEAR MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

US

MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3800 W. BELVEDERE AVE.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3800 W. BELVEDERE AVE.

14. FATHER'S NAME

FIRST MIDDLE LAST
NATHEN

WOODYARD

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
ANNA

MAE

COOK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

ADDRESS
CHART

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:

(b)

Metastatic Carcinoma Abdomen

DUE TO, OR AS A CONSEQUENCE OF

(c)

with Anemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/27/87, 1987, to 8/28/87, 1987, that (I) (we) lost the deceased alive on 8/28/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8-28-87

23c. NAME OF CEMETERY OR CREMATORY

ELSWORTH CEMT.

23d. LOCATION

CITY OR TOWN COUNTY STATE
WESTMINSTER MARYLAND

24. FUNERAL DIRECTOR

NAME
E.L. PHILLIPS

1721 N. MONROE STREET

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

SEP 2

1987

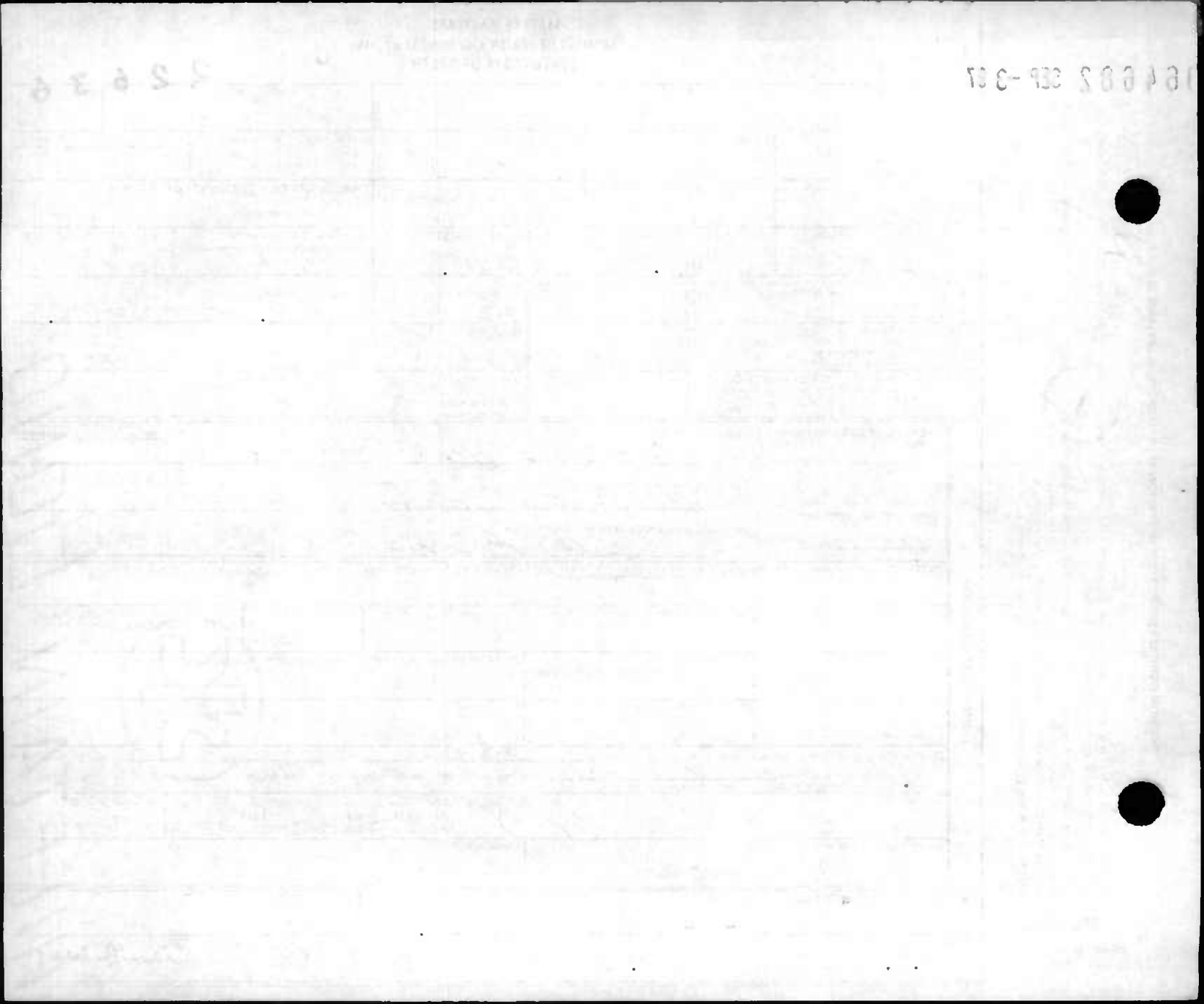
Julia Davidson-Randall

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22637

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>SARAH E. Diggs</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 17 87</i>			2b. HOURS MIN. <i>3:45</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 4 26</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>61</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore city</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE <i>2868 W. Lanvale St 21216</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Claude Davis</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>212-78-3825</i>		17. INFORMANT ADDRESS <i>Kaye F. Miller 2868 W. Lanvale St</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Shock*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *MI*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Arteriosclerosis*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/16/87</i> , 19 <i>87</i> , to <i>8/17</i> , 19 <i>87</i> that (I) (we) lost saw the deceased alive on <i>8/17</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Colonel M. Sabundog</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/17/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Colonel M. Sabundog</i>				22e. ADDRESS <i>Bon Secours Hospital</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/21/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landsdown MD</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H West</i>				ADDRESS <i>4300 Wabash Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 24 1987</i>	
				25b. REGISTRAR'S SIGNATURE <i>James Denson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please ensure complete proper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 2 2 0 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) A. GENEVA DIXON			2a. DATE OF DEATH MONTH DAY YEAR August 23 1987		2b. HOUR 9 20 P.M.
3. SEX FEMALE	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 8 18 35		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) So. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balt.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balt. City Schools
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Balt.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Lucius Felder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corine Mack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 247-48-4963		17. INFORMANT ADDRESS William E. Dixon 4101 Kathland Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BREAST CARCINOMA WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/21 19 87 to 8/23 19 87, that (we) lost saw the deceased alive on 8/23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. Miller, D		DEGREE		22c. DATE SIGNED 8/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS S. MILLER, MD		22e. ADDRESS Bon Secours Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-27-87	23c. NAME OF CEMETERY OR CREMATORY Arbutus MEY PK	23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, MD		
24. FUNERAL DIRECTOR NAME Wm C. March West 4300 Wabash			25. DATE REC'D BY REGISTRAR AUG 27 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be certified within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. This form should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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AUG 31 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22639

1 - FOR
STATE
REGISTRAR

REG. NO.

064275 AUG 31 1987

1. DECEASED NAME (FIRST MIDDLE LAST) MARY Dobkin			2a. DATE OF DEATH MONTH DAY YEAR 08-22-87			2b. HOUR 615 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 30 03		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale Nsg Home				12. USUAL OCCUPATION DIABETIC NURSE		13. KIND OF BUSINESS OR INDUSTRY CALL CENTER FUND	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3899 SINCLEAR LANE 21213	
14. FATHER'S NAME (FIRST MIDDLE LAST) WILLIAM DOBKIN			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) SARAH TURKOFF						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-18-4845T		17. INFORMANT RALPH KATZ		ADDRESS 2922 STRATHMORE AVE. (21209)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO-VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-7 , 19 85 , to 8-22 , 19 87 , that (I) (we) last saw the deceased alive on 8-21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. H. H. H.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8.23.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SE H. H. H.			22e. ADDRESS Levindale 2431 W. Belvidere Ave Baltimore Md. 21215						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTO. MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)					25. DATE REC'D. BY REGISTRAR AUG 28 1987 REGISTER SIGNATURE John Fisher-Rudolph				

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RECEIVED MAY 10 1981

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

201012

U.S. FBI

063056 AUG 18 1987

Items 6+13 per phone
FOR STATE REGISTRAR
8/31/87 DADSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH67 22640
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Dorsey			2a. DATE OF DEATH MONTH DAY YEAR 8/17/87 08 17 87		2b. HOUR 3:54 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 15 1884		6. AGE (IN YEARS LAST BIRTHDAY) 103	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN 103
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown	7b. CITIZEN OF WHAT COUNTRY? USA		8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		MD
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOSPITAL, GIVE FACILITY, STREET ADDRESS) North Charles		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1114 Cathedral St. 21201
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 219-30-646		17. INFORMANT NAME ADDRESS Rharry Alexander 1114 Cathedral St 21202	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF, (c) Multiple decubitus ulcers APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary artery disease renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 07/30/87 to 8/17/87 , that (I) (we) last saw the deceased alive on 8/17/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DESAI		22e. ADDRESS North Charles Hospital Baltimore			
23a. BURIAL, CREMATION, REMOVAL (NOTIFY)	23b. DATE 8 20 87	23c. NAME OF CEMETERY OR CREMATORY Cath Zion	23d. LOCATION (CITY OR TOWN COUNTY STATE) Baltimore md		
24. FUNERAL DIRECTOR William McLean		ADDRESS 2822 W North		25a. DATE RECD. BY REGISTRAR AUG 17 1987	

063028 AUG 18 87

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063980 AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22641
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donya Marcel Dorsey			2a. DATE OF DEATH MONTH DAY YEAR 8 21 87		2b. HOUR 04:07 AM
3. SEX ♂	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 14 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 0 7	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY V	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Victor (McLeod)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lisa D. Dorsey		16. SOCIAL SECURITY NO. NA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT Fischgrund		ADDRESS U. of Md Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Necrotizing Enterocolitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min 24 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Sepsis</u>					
19a. DATE OF OPERATION 8/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Necrotizing Enterocolitis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14/87</u> , 19 <u>87</u> , to <u>8/21</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased <u>die</u> on <u>8/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fischgrund		22e. ADDRESS U. of Maryland Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/25/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR AUG 26 1987			
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22042
22642
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Betty J. Down3</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8-13-87</i>		2b. HOUR MIN <i>6³² A M</i>	
3. SEX <i>F</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>6-10-45</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>42</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MD</i>		13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ray Matthew</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Inez McBarther</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-44-0415</i>		17. INFORMANT ADDRESS <i>Chay</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC BREAST CANCER</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>RENAL FAILURE</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>HEPATIC FAILURE SECONDARY TO METASTATIC CANCER</i>					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 10</i> , 19 <i>87</i> to <i>AUGUST 13</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>Aug 12</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>M. Kerth Rawlings</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/13/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. Kerth Rawlings, MD</i>		22e. ADDRESS <i>1701 W. PRATT ST. BALTO. MD 21223</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>8-19-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. ZION</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Nancy Wallace 3405 W. Fennell</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 20 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Jordan-Randall</i>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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061822 AUG -5187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22643

1. DECEASED NAME (TYPE OR PRINT) THOMAS KERNAN DOYLE			2a. DATE OF DEATH MONTH DAY YEAR 08 1 87			2b. HOUR 12:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 1 1857		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Pa. RR		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1541 Shadyside Road 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Doyle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Shernin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 717-07-7759		17. INFORMANT ADDRESS Margaret Doyle 1541 Shadyside Road 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF (c) CNF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Melton H. Hagan				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melton H. Hagan				22e. ADDRESS Good Samaritan Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-5-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				ADDRESS 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR AUG 04 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Rodriguez	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1855 AUG-20

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22644

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID DRAKE			2a. DATE OF DEATH MONTH DAY YEAR 8 25 87			2b. HOUR 2:35 PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 18 10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Vernon Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			
12b. KIND OF BUSINESS OR INDUSTRY Retired		13a. STATE md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Un Known		16. SOCIAL SECURITY NO. 218-10-7886					
17. INFORMANT Glen Burnie 21061		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordicereparatory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED IN PLACE <input type="checkbox"/> NOT IN PLACE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> 19 <u>87</u> , to <u>8/25</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>8/25</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER MD.		22e. ADDRESS 7445 FURNACE BRANCH Rd		22f. DATE REC'D. BY REGISTRAR AUG 26 1987					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8-26-87		23c. NAME OF CEMETERY OR CREMATORY GARRISON Forest		23d. LOCATION CITY OR TOWN COUNTY STATE GARRISON MD			
24. SIGNATURE OF REGISTRAR Marshall W. Jones, JR. FH 41016		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall		26. REGISTRAR'S SIGNATURE AUG 26 1987					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper and page 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner will be notified at once.

08382 AUG 29 67

063262 AUG 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22645

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Mary Ann Draper			08/13/87			12:25A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE			7. BALTIMORE CITY OR COUNTY OF DEATH		
FEMALE	WHITE	DECEMBER 26, 1935	51 YRS			Baltimore City MD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
DELAWARE	USA		DATA ENTRY CLERK			FROZEN FOOD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS / ZIP CODE			13b. STREET ADDRESS / ZIP CODE		
Baltimore	Union Memorial Hospital		R.D. 1 BOX 80B 19952			19952		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
DELAWARE			KENT			HARRINGTON		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
CLARENCE W. BARLOW			PAULINE KINMI RYAN			222-22-7631		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			222-22-7631			C. WARREN DRAPER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>OVARIAN CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
8/11/87			SMALL BOWEL OBSTRUCTION 2°CA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I (this hospital) attended the deceased from <u>8/13</u> 19 <u>87</u> to <u>8/13/87</u> 19 <u>87</u> that (I (we)) last saw the deceased alive on <u>8/13</u> 19 <u>87</u> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I (we)) did not view the body after death.			22b. SIGNATURE <u>Gina L. Sager M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22c. DATE SIGNED <u>8/13/87</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gina L. Sager, M.D.</u>					
22e. ADDRESS <u>Union Memorial Hospital</u>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>					
23b. DATE <u>8/16/87</u>			23c. NAME OF CEMETERY OR CREMATORY <u>HOLLYWOOD CEMETERY</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>HARRINGTON KENT DELAWARE</u>		
24. FUNERAL DIRECTOR <u>LEWIS D. McKNATT</u>			25. DATE RECEIVED BY REGISTRAR <u>AUG 17 1987</u>			26. REGISTRAR'S SIGNATURE <u>L. D. McKnatt</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please to file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or else.

RECEIVED
 AUG 1 1950
 WASHINGTON
 DEPT. OF THE ARMY
 OFFICE OF THE ADJUTANT GENERAL
 WASHINGTON, D. C. 20315
 NO. 1
 SUBJECT: [illegible]
 REFERENCE: [illegible]
 ACTION: [illegible]
 DISTRIBUTION: [illegible]
 APPROVED: [illegible]
 SPECIAL AGENT IN CHARGE

RECEIVED
 AUG 1 1950
 WASHINGTON
 DEPT. OF THE ARMY
 OFFICE OF THE ADJUTANT GENERAL
 WASHINGTON, D. C. 20315
 NO. 1
 SUBJECT: [illegible]
 REFERENCE: [illegible]
 ACTION: [illegible]
 DISTRIBUTION: [illegible]
 APPROVED: [illegible]
 SPECIAL AGENT IN CHARGE

063327 AUG 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22646

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LEE DRAUN			2a. DATE OF DEATH MONTH DAY YEAR 08 13 87			2b. HOUR 7:15 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 26 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC CTR				12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY FOOD-MARKET		
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STATE ADDRESS 2601 FORDS DA. HARSHMAN HOUSE ST BALTIMORE MD	
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN SAPPERSTEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SAKS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 216-07-4162	
17. INFORMANT MRS. FAE KAPLAN 7 SLADE AVE. BALTO., MD			18. ADDRESS APT. 314 21208			19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 8/13/87 to 8/13/87, that (we) last saw the deceased alive on 8/13/87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.										
22b. SIGNATURE ESTRELLITA O. KUN			DEGREE M.D.			22c. DATE SIGNED 8/13/87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELLITA O. KUN	
22e. ADDRESS LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL			22f. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELLITA O. KUN			22g. ADDRESS LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 14, 1987			23c. NAME OF CEMETERY OR CREMATORY GREATER BALTO. LODGE			23d. LOCATION BALTIMORE COUNTY MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D BY REGISTRAR AUG 20 1987			25b. REGISTRAR'S SIGNATURE Julia Tison Rucker				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0633327 10251 81

RECEIVED 10/10/50

10251 10251 10251

062194 AUG 10 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87
REG. NO.

22647

1. DECEASED NAME (TYPE OR PRINT) Roscoe			2a. DATE OF DEATH MONTH DAY YEAR August 5 1987			2b. HOUR 5⁵⁵ AM			
3. SEX M	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 3 5 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Willis Dunn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Hughes		13e. STREET ADDRESS / ZIP CODE 1100 Bolton Street Apt 804 21201					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-09-2755		17. INFORMANT ADDRESS LARRY DUNN 2543 SEAMON AVE. 21225					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colorectal carcinoma with metastasis DUE TO, OR AS A CONSEQUENCE OF (b) Colorectal carcinoma with metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis (error will) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal failure secondary to obstructive uropathy									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 4 , 19 87 , to Aug 5 , 19 87 , that (I) (we) last saw the deceased alive on August 4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William C. Congers				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C. Congers				22e. ADDRESS 120 S. Greene St. Dept Family Medicine					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/8/87		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME LEROY O. DYETT				ADDRESS 4600 LIBERTY HEIGHTS		25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

085134 AUG 10 81

789 7 314

062743

AUG 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22648
22648
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
WARREN C. EASTBURN			Aug. 9, 1987			6:15 P		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	May 21, 1921	66			MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Delaware	USA			Baltimore City MD.				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Baltimore	132 South Patterson Park Ave.			Contractor			Construction	
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE				
Delaware	Sussex	Bethany Beach	NO <input type="checkbox"/>	Surf & Ayres Rds. 19930				
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Henry C. Eastburn			Ethel Hawthorne					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT			
Yes			WW 2		Brenda D. Eastburn P.O. Box 1168			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			APPROXIMATE TIME ELAPSED BETWEEN DEATH AND EXAMINATION					
IMMEDIATE CAUSE (a) metastatic Bladder Carcinoma			18 months					
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)					
DUE TO, OR AS A CONSEQUENCE OF			(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 8-9 1987, to 8-9 1987, that (I) (we) lost saw the deceased alive on 8-9 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b SIGNATURE J. Williams MD			22c DATE SIGNED 8-9-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS					
KENNETH WILLIAMS			740 S. Conkling St. Bk 6.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE	23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE	
Burial			8/13/87	Gracelawn Mem. Park			Minquadale, New Castle, Del.	
24 FUNERAL DIRECTOR			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Robert T. Jones			AUG 13 1987			J. Williams		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

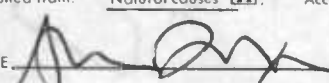

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RESEARCH DESIGN

062589 AUG 13 87

FOR
STATE
GISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH22649
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Charles			MIDDLE Eaton			LAST Eaton			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 8			DAY 8			YEAR 19 87			2b. HOUR M											
3. SEX M			4. RACE B2			5. DATE OF BIRTH MONTH DAY YEAR 5 5 19			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 8 19 87			2d. HOUR 10 A														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.						7b. CITIZEN OF WHAT COUNTRY? America						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD																	
10. CITY OR TOWN OF DEATH Baltimore						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1348 Division Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY																	
13a. STATE MD						13b. COUNTY						13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 1348 Division St. 21217											
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Eaton						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Marie Norwood						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 215-12-4587						17. INFORMANT Murriel Jones 606 W. Lafayette											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Diabetes mellitus</u>																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																			
ACTUAL SIGNATURE 						TITLE (SPECIFY) Deputy Chief M.D. MEDICAL EXAMINER												DATE SIGNED 8/ 8/87																	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St. Balto.MD.																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 8/13/87						23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem						23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.																	
24. FUNERAL DIRECTOR NAME James A. Montoye & sons												ADDRESS												25a. DATE REC'D. BY REGISTRAR AUG 11 1987						25b. REGISTRAR'S SIGNATURE 					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

065282 WPC 1301

QUESTA NOTTE

WAVE



WAVE 1301

63785 AUG 26 87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilson A. EDMONDSON				2a. DATE OF DEATH MONTH DAY YEAR August 7, 1987		2b. HOUR 9:05A M	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 26 12		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 	
12b. KIND OF BUSINESS OR INDUSTRY 		13a. STATE Md					
13b. COUNTY 		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4049 Edgewood Road 21215	
14. FATHER'S NAME FIRST MIDDLE LAST James Edmondson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Walker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 228-01-0033		17. INFORMANT Charlie Edmondson				ADDRESS 2900 Poplar Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 6 , 19 87 , to August 7 , 19 87 , that I (we) last saw the deceased alive on August 7 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE <i>Samir Shabshab</i>				DEGREE		22c. DATE SIGNED 8/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samir Shabshab, M.D.				22e. ADDRESS c/o Marylsnd General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/87		23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE <i>John R. Baker</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate and placed in the file of the deceased. The funeral director should also remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

03782 AUG 28 87

63604 AUG 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22051

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard William Edrington			2a. DATE OF DEATH MONTH DAY YEAR 08 21 87			2b. HOUR P M 4:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 14 55		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4307 Grand View Avenue 21211				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Marvin Edrington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Rosier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Marvin Edrington 1339 W. 37th Street 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung CA.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> , 19 <u>87</u> , to <u>8/21</u> , 19 <u>87</u> , that (I) <u>last</u> saw the deceased alive on <u>8/18/87</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(was not)</u> (did not) view the body after death.							
22b. SIGNATURE <u>Alan B. Cohen</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/25/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alan B. Cohen</u>		22e. ADDRESS <u>201 E Univ Park Ball Md 21218</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY Forest Baptist Ch. Cem. Upperco		23d. LOCATION CITY OR TOWN COUNTY STATE Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a. DATE REC'D BY REGISTRAR <u>AUG 24 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 will be filed with 72 hours after death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

03001 AUG 22 05

RECEIVED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

064393 SEP - 1 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 0 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN LEE EDWARDS			2a. DATE OF DEATH MONTH DAY YEAR 8 27 87		2b. HOUR 1:15pm M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 13 24		6. AGE (IN YEARS LAST BIRTHDAY) 62
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH #212/3 1927 E. LAFAYETTE AVE MD
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Ctr.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Edwards			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bethany ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) Warte 244-20-4664		17. INFORMANT ADDRESS Pearlie Mosley #212/3 2327 E. LAFAYETTE AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular arrhythmia - cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic renal failure on hemodialysis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/27 19 87 , to 8/27 19 87 , that (I) (we) last saw the deceased alive on 8/27 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE J.B. Zachary, M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.B. Zachary, M.D.			22e. ADDRESS 4940 Eastern Avenue, Balto., MD 21224			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE 9-1-87		23c. NAME OF CEMETERY OR CREMATORY Garfield Forest Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dring's Mills MD
24. FUNERAL DIRECTOR NAME Betts Funeral Home			ADDRESS 10211 Caroline ST		25a. DATE REC'D. BY REGISTRAR AUG 31 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director and be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified immediately.

004 303 SEP-1-81

ANG 21 200

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 6 5 3

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (OR PRINT) NATHAN EGLICHEN			2a. DATE OF DEATH MONTH DAY YEAR 08 15 87			2b. HOUR MIN. 6:11 A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DAY MONTH YEAR DEC. 1, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST		12b. KIND OF BUSINESS OR INDUSTRY DRUGS	
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2500 W. BELVEDERE AVE. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL EGLICHEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA MUSKIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 087-22-9199		17. INFORMANT ADDRESS MRS. BRENDA L. BUCK 501 W. FRANKLIN ST. BALTO., MD 21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF SEIZURES DISORDERS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) HYPERTENSION (c) HYPERTENSION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 87 , to 8/15 , 19 87 , that (I) (we) lost 8/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE		22c. DATESIGNED 8/15/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER IMPAGLIATELLI, M.D.					22e. ADDRESS CHURCH HOSPITAL 100N. BROADWAY, BALTIMORE, MD. 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					25. DATE OF REGISTRATION AUG 25 1987 BY REGISTRAR'S SIGNATURE <i>[Signature]</i>				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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003005 AUG 28 61

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22054

1 DECEASED NAME (TYPE OR PRINT) ABRAHAM EISENBERG			2a. DATE OF DEATH MONTH 8 DAY 16 YEAR 87 HOUR 7:55 PM		
3 SEX MALE	4 RACE CACASIAN	5 DATE OF BIRTH MONTH 10 DAY 13 YEAR 93	6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7b. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI of Balt.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY RADIATOR REPAIR
13a. STATE MARYLAND	13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MEDEL MIDDLE EISENBERG LAST ETHEL		15 MOTHER'S MAIDEN NAME FIRST ETHEL MIDDLE NIZINSKI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-32-9815		17 INFORMANT JOSEPH EISENBERG	
16c. (IF YES, GIVE WAR OR DATES) WWI-ARMY		17 ADDRESS 5903 EASTCLIFF DR. BALTO., MD 21209			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Parkinson Rx DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 8/2 , 19 87 , to 8/16 , 19 87 , that (1) (we) last saw the deceased alive on 8/16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Draper		DEGREE M.D.		22c. DATE SIGNED 8/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lois Draper		22e. ADDRESS SINAI Hospital of Balt.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION	
23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD					
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE RECD BY REGISTRAR AUG 20 1987			
		25b. REGISTRAR'S SIGNATURE Julia Bender-Randall			

BP

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063931 AUG 27 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22055
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ZONIA			FIRST MIDDLE LAST ELIE			2a. DATE OF DEATH MONTH DAY YEAR AUG 21 87			2b. HOUR 628P_M		
3. SEX female			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR 10 24 1945			6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) REP. of PAN			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RN			12b. KIND OF BUSINESS OR INDUSTRY PRIVATE		
13a. STATE MD			13b. COUNTY BALTO.			13c. CITY OR TOWN BALTO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CECIL BROWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE BELLE LEVI			13e. STREET ADDRESS / ZIP CODE 5455 BELLE VISTA AVE. 21206					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 079-36-5260			17. INFORMANT ADDRESS HAENFR ELIE 5455 BELLE VISTA AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) CARDIOPULMONARY ARREST									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CHRONIC MYELOCYTIC LEUKEMIA (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. J. Hart						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/21/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA J. EHART						22e. ADDRESS GSH					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/26/87		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN, MD			
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.						25a. DATE REC'D. BY REGISTRAR AUG 25 1987					
25b. REGISTRAR'S SIGNATURE Julia Fender-Rudolph											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

003331 AUG 55 81

3

AUG 5 5 1955

062264 AUG

Items, 18a., 21b., - 22a., G-631, 9/21/87

STATE OF MARYLAND

FOR by Med. Ex., / Gbj.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 0 5 0

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ATTACHING WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
William J. Elliott						8 7 19 87						M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		White		Dec. 7, 1912		74 YRS.		MONTHS DAYS HOURS MIN.				8 7 19 87		10:16 a M			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland				U.S.A.								Baltimore City MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				Francis Scott Key Medical Center				Restaurant Mgr.									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland				Baltimore		Eastpoint		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7947 Lansdale Road 21224							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Joseph Elliott						Augusta Heinrich											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
Yes						Navy WW II						215-01-5144					
						Dorothy H. Elliott						7947 Lansdale Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple drug intoxication																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY?																	
BODY ONLY				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 8 7 19 87				Subject ingested drugs.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE					
				home				7947 Lansdale Road, Baltimore,				Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED					
				Deputy Chief								8/8/87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								BALTO.MD.					
Ann M. Dixon, M.D.				111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				CITY OR TOWN COUNTY STATE			
Burial				Aug 10 1987		Moreland Memorial				Baltimore				Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc.				Baltimore, Maryland								AUG 10 1987				Julia Anderson-Randall	

07/84
25M

BP 708
DHMH - 17
(VR A15 ME (5))

082284 AUG 11 67

DATE: AUG. 11, 1967

U.S.A.

RECEIVED

Very much interested in your letter of August 10, 1967.

Joseph

Yes, my name is Joseph H. Elliott, 1947-1948.



[Handwritten signature]

ENTIRE

RECEIVED

AUG 10 1967

Joseph H. Elliott, Inc.

064740 SEP-487

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22657

1. DECEASED NAME (TYPE OR PRINT) JOHN H ELTERMAN			2a. DATE OF DEATH MONTH 8 DAY 27 YEAR 87		2b. HOUR 9:55 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 7 DAY 27 YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Organist & Master		12b. KIND OF BUSINESS OR INDUSTRY Choir
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto., Md.			14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST 			15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE UNKNOWN LAST 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-01-5008		17. INFORMANT Mr. John A. Eltermann ADDRESS 6709 Seneca Dr.-Columbia, Md. #21046	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 3rd degree burns					8 days
DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/14/87 to 8/27 19 87 , that (I) (we) last saw the deceased alive on 8/27 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Nadine B Semer MD				DEGREE MD	22c. DATE SIGNED 8/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nadine B Semer MD				22e. ADDRESS Francis Scott Key Hospital/Burn Unit	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 31, 1987	23c. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR G. Truman Schwab			25a. DATE REC'D. BY REGISTRAR SEP 3 1987		
25b. REGISTRAR'S SIGNATURE Min. Tindon-Lundee			25c. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 2 and 3 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND

REG. NO.

2 2 6 5 8

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8722658									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P.M.									
CATHERINE E. ENEY AUGUST 4, 1987 3:30 P.M.									
3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS.									
FEMALE WHITE AUGUST 25 1930 56 YRS MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED [] NEVER MARRIED [] WIDOWED [x] DIVORCED [] 9. BALTIMORE CITY OR COUNTY OF DEATH									
MD. U.S.A. BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY									
BALTIMORE 4306 CLAREWAY HOMEMAKER -									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE									
MD. - BALTIMORE YES [x] NO [] 4306 CLAREWAY 21213									
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
CLARENCE FOARD ROSIE E. FISHER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS									
NO 220-24-9500 SHERRY MATNEY (DGHTR) 258 COLGATE AVE 21222									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from 6/24/87 9/1/87, 19 83 to 8/4/87, 19 87, that (I) (we) lost saw the deceased alive on 8/3/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE 22c. DATE SIGNED									
DR. DENNIS MAC DONALD 9 S. HIGHLAND AVE. 8/6/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS									
DR. DENNIS MAC DONALD 9 S. HIGHLAND AVE.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL 8/8/87 MORELAND MEM PK BALTIMORE MD.									
24. FUNERAL DIRECTOR'S NAME 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
CHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213 AUG 07 1987 Julia Dendron-Rodman									

025139 VME 1081

025139 VME 1081

064065 AUG 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 22659

1. DECEASED NAME (TYPE OR PRINT) JERRY			FIRST ENGLISH			LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-22-87 MATED <input type="checkbox"/>			2b. HOUR M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 3 49		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 8-22-87		2d. HOUR 3:45P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OKLAHOMA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER				12b. KIND OF BUSINESS OR INDUSTRY PAINTING			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MISSOURI 13b. COUNTY SIKESTON 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 815 E. KATHLEEN ST.	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR ENGLISH						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUBY LOUISE LAMBERT ENGLISH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 440-50-0786				17. INFORMANT ADDRESS MARY ANN DAILING - SISTER same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8122 IMMEDIATE CAUSE (a) Head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 8-14-87 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of motorcycle/auto collision									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 200blk. S. Broadway Baltimore, Maryland 1001t. S. of Pratt St.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 8-24-87							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL				23b. DATE 8-24-87		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.				25. I HEREBY CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL. AUG 27 1987 <i>John S. Sander</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMM - 17
(VR A15 ME (15))

20% COTTON LIGHT




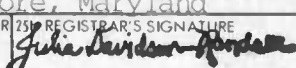
084002 AUG 58 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

New Certificate FOR STATE FilmG631 9/14/87jab REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 7 2 2 6 6 0			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia M. English				2a. DATE OF DEATH MONTH DAY YEAR 8 15 87				2b. HOUR 8:03 p.m.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 01 47		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 72 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4540 Manor View Road 21229	
14. FATHER'S NAME FIRST MIDDLE LAST John David Montgomery, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmena Charles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-52-7204		17. INFORMANT ADDRESS Hospital Records 3001 S. Hanover Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With metastases to liver and brain DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) -							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE - - - - -							
22a. I certify that (I) (this hospital) attended the deceased from 14 August 19 87, to 15 August 19 87, that (I) (we) last saw the deceased alive on 15 August 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred Klein				22e. ADDRESS 3001 South Hanover Street Baltimore, Maryland 21230							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-2-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Oden & Gibson, Baltimore, Maryland				25a. DATE REGD. BY REGISTRAR SEP 14 1987		25b. REGISTRAR'S SIGNATURE 					

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22661
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 2687 Richard ENNIS			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1987		2b. HOUR 2:00 AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH 4 MONTH 7 DAY 1934 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN DEATON MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES ENNIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGINNA ISSAC		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-26-7511	17. INFORMANT Severna Park, Md. 21146 FRANCIS JACKSON, Jr. 102 Sylvan Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF, pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/17/87, 19 87, to 8/17/87, 19 87, that (I) (we) last saw the deceased alive on 8/17/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William C. Conyers MD		DEGREE		22c. DATE SIGNED 8/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C. Conyers		22e. ADDRESS 1205 Greene St			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 8-20-1987	23c. NAME OF CEMETERY OR CREMATORY CARPENTER HILL CEME.		23d. LOCATION CITY OR TOWN COUNTY STATE Round Bay A.A. Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.			25a. DATE REC'D. BY REGISTRAR AUG 25 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

06383 AUG 29 81

Aug 25 1987 Jim Harkin

063381 AUG 21 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22662
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH C. ERTEL			2a. DATE OF DEATH MONTH DAY YEAR 8 15 87		2b. HOUR MIN. 10 25 AM					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 23 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS 87		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATH HOSP. - MED. CENTER - SOUTH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEELWORKER		12b. KIND OF BUSINESS OR INDUSTRY FACTORY				
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2275 LAKE DR. 2122	
14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN) ERTEL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (MARGARET) NUESSEIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213 07 5996		17. INFORMANT JOSEPH BILANGER (SAME AS 13a-E)				ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebrovascular accident 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/15 19 87 to 8/15 19 87 , that (I) (we) last saw the deceased alive on 8/15 19 87 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Skauonem				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANI S. KARI PINENI				22e. ADDRESS 200 Hospital Drive Glenburne MD 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-18-87		23c. NAME OF CEMETERY OR CREMATORY ONK LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTO. MD.				
24. FUNERAL DIRECTOR NAME McGully FUNERAL HOMES				ADDRESS 3204 MOUNTAIN RD PASADENA, MD 2122		25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notated as such.

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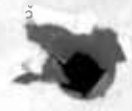
1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication from the President to the Congress since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Union at that time. It is a document that is well worth reading, and it is one that should be kept in a safe place for future reference.

2. The second part of the document is a letter from the Secretary of the War to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the War to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the War at that time. It is a document that is well worth reading, and it is one that should be kept in a safe place for future reference.

3. The third part of the document is a letter from the Secretary of the Navy to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the Navy to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Navy at that time. It is a document that is well worth reading, and it is one that should be kept in a safe place for future reference.

4. The fourth part of the document is a letter from the Secretary of the Treasury to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the Treasury to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Treasury at that time. It is a document that is well worth reading, and it is one that should be kept in a safe place for future reference.

5. The fifth part of the document is a letter from the Secretary of the Interior to the President, dated January 1, 1861. It is a very important document, as it is the first official communication from the Secretary of the Interior to the President since the inauguration of Abraham Lincoln. The letter is written in a formal, dignified style, and it contains a great deal of information about the state of the Interior at that time. It is a document that is well worth reading, and it is one that should be kept in a safe place for future reference.



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Item 5, 6, per/inf.

FOR
STATE 9-22-87 dw
REGISTRAR film G631STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22004

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
James		Evans		8		8		87 3:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	Black	MONTH 6 DAY 6 YEAR 1910		77		87 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
A/A.	U.S.A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Mt. Vernon Care Center								

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1622 Appleton St. 21217	

14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST	FIRST MIDDLE LAST		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unknown		232-16-0735		Johnnie Mae Add.		304 1630 Monasterial Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Poisoning M.I.</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) <u>As a result of</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) <u>Arteriosclerosis</u>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>							

22a. I certify that (I) (this hospital) attended the deceased from 8/5, 1987, to 8/5, 1987, that (I) (we) last saw the deceased alive on 8/5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Ashok K. Chatterjee</u>				8/10/87	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
ASHOK K. CHATTERJEE, M.D., P.A.		3927 ANNAPOLIS ROAD, BALTO., MD. 21227	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		8/12/87		Eastview Mem PK		BALTO. MD.	

24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
REESE, J. SPENCER 821 WEST MARYLAND		AUG 11 1987		<u>Johnnie Mae Add.</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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WILLIAM BOND



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 FOR STATE
 1- STATE
 REG. NO. AR
 1- DECEASED NAME
 (TYPE OR PRINT)

FIRST

MIDDLE

LAST

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 2a. DATE KNOWN OF DEATH
 ESTIMATED ☒ MONTH DAY YEAR
 8-9-87 19

7b. HOUR

 3 SEX male 4 RACE Black 5. DATE OF BIRTH MONTH DAY YEAR 9 5 37 6. AGE (IN YEARS) (LAST BIRTHDAY) 49 RS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. 2c. DATE PRONOUNCED DEAD 8-9-87 19 7d. HOUR 5:01 PM

 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 9b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

 13a. STATE MD 13b. COUNTY Har 13c. CITY OR TOWN Balto 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET ADDRESS 1331 Myrtle Ave. 21217

 14. FATHER'S NAME FIRST MIDDLE LAST George D. Evans 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Jimenez

 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 244-13-1318 17. INFORMANT Margie B. 216 Calloway Ave Bal 21216 ADDRESS

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 19c. AUTOPSY? YES ☒ NO ☐

 20a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 PM P.M. 8-8-87 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2) subject fell from a 2 story dwelling roof

 21a. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK ☒ 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home 21c. LOCATION (CITY OR TOWN, COUNTY, STATE) 1331 Myrtle Avenue Baltimore, Maryland

 22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

 ACTUAL SIGNATURE Margie McKeel TITLE (SPECIFY) Assistant M.D. Assistant MEDICAL EXAMINER DATE SIGNED 8-10-87

 EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8-17-87 23c. NAME OF CEMETERY OR CREMATORY St. John 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Baltimore

 24. FUNERAL DIRECTOR'S NAME Althea B. McKeel ADDRESS 8802 W. Belknap 25a. DATE REC'D. BY REGISTRAR AUG 13 1987 25b. REGISTRAR'S SIGNATURE Julia Twicken-Budroe

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARAKA W. HARRY EWALT
WILLIAM HARRY EWALTSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22666
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM H. EWALT			2a. DATE OF DEATH MONTH DAY YEAR Aug. 26 1987		2b. HOUR 2:02 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR July 1, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY BALTO. BUSINESS
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HARRY EWALT SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE HARRIET W. BAKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 215-07-1213A		17. INFORMANT ADDRESS MD. 21201 RICHARD KIEFER 343 N. CHARLES ST. BALTO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (he) (this hospital) attended the deceased from July 29, 1987, to Aug 26, 1987, that (he) (we) lost saw the deceased alive on Aug 26, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE BERT F. MORTON		DEGREE M.D.		22c. DATE SIGNED Aug 27, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON		22e. ADDRESS ST. AGNES HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08/29/87	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE. CATONSVILLE, MD 21228			DATE REC'D. BY REGISTRAR AUG 31 1987		
25. REGISTRAR'S SIGNATURE Julia Tindon-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.

BP

004302 209-107

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DECEASED NAME Ruth Lenora Fairall		August 23-87		10 PM	
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH Jan - 28 - 1911	6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland Howard Co.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SETON HILL MANOR		12a. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN Arnold	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		
14. FATHER'S NAME FIRST MIDDLE LAST Robert R. SPECHT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE L Brengle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 216-03-7965		17 INFORMANT (att'y.) ADDRESS Stanley Dr. Catonsville, Md. Howard L. Muhl, Jr.	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Opportunistic Infection DUE TO, OR AS A CONSEQUENCE OF (b) Acquired Immune Deficiency Syn. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK - 3 mos.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 8-23 to 8-23, 19 87, that (I) (we) lost saw the deceased alive on 8-23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jaime Punzalan		DEGREE MD		22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAIME PUNZALAN		22e. ADDRESS 5214 Hanford rd. Balto. Md. 21214			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 24, 87		23c. NAME OF CEMETERY OR CREMATORY Security Process	
23d. LOCATION CITY OR TOWN Catonsville		23e. COUNTY Balt.		23f. STATE Md.	
24 FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR AUG 25 1987			
25b. REGISTRAR'S SIGNATURE Jana W. H. H. H.					

003303 AUG 28 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22068

REG. NO.

63688 AUG 25 87

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JUNE BERNICE FALISE		AUGUST 20, 1987		9:15A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	WHITE	01 - 08 - 29	58 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
BALTIMORE, MD	U.S.A.		BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL	CLERK	GROCERY		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
MARYLAND	CARROLL	WOODBINE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS / ZIP CODE			
JOHN E. BELL	HILDA	1428 HOODS MILL ROAD 21797			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
NO	?	Frank Falise			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST					30 MINS
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
(b) ADENOCARCINOMA OF UNKNOWN PRIMARY					2 YRS
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: BREAST CARCINOMA - INfiltrATING DUCTAL					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 18 19 87 to AUGUST 20 19 87, that (I) (we) lost saw the deceased alive on AUGUST 19 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE	DEGREE				22c. DATE SIGNED
ERIC B. LIEBERMAN	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				8/26/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
ERIC B. LIEBERMAN	600 N. WOLFE ST BALTIMORE MD 21205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	08-24-87	CRESTLAWN CEMETERY	MARRIOTSVILLE HOWARD MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME HAIGHT FUNERAL HOME P.O. BOX 195 SYKESVILLE		AUG 24 1987		Jill Davidson-Randall	

06389 88267

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all tags, papers, 1 and 2 and deposit them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
GRACE		J.		FARLEY				8/7/87								5:30pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		Black		MONTH DAY YEAR 6 4 30		47 YRS.		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia		USA				Baltimore										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		No. Charles General Hospital		Homemaker													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Maryland		Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 Alton Street 21001									
FATHER'S NAME		MOTHER'S MAIDEN NAME		15. ADDRESS													
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
Sterling		Bailey		Elizabeth		Bailey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		N/A		224-48-7478		Francisca Farley		Same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
				CARDIO Respiratory Failure		Metastatic Ovarian Carcinoma				3 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				NONE													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
8/7/87				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) this hospital attended the deceased from 7/24/87 to 8/7/87, that (I) we lost saw the deceased alive on 8/7/87, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
Brent C. Birely				8/7/87													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Brent C. Birely		N-Charles Gen. Hospital															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		8/11/87		Arlington Nat. Cem.		Arlington Arlington Va.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Tarring Funeral Home, PA. Aberdeen, Md. 21001-3399				AUG 11 1987		Julia Gordon-Rodale											

BP

065200 AUG 13 83

10



20% CELL ON LINES



62455 AUG 12 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

22670

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID M Faulk			2a. DATE OF DEATH MONTH DAY YEAR 8/10/87		2b. HOUR 1:00 A.M.
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 23 01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH B. City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALT.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 216-42-0895		17. INFORMANT ADDRESS Deaton Nursing Home - 6115. Charles St			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the larynx.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HTN SP Tracheostomy</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Anemia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK		22e. ADDRESS 3001 S. Hanover St, BALT. MD 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/14/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cn.		23d. LOCATION CITY OR TOWN COUNTY STATE Bk. County MD	
24. FUNERAL DIRECTOR NAME Irvin Carroll		ADDRESS 1712-14 N. North Ave		25a. DATE REC'D. BY REGISTRAR AUG 11 1987	
				25b. REGISTRAR'S SIGNATURE Julia Barker	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

085422 VME 15 81



RECEIVED - MOTOR ROOM

10/10/81

10/10/81

10/10/81

10/10/81

064545 SEP-287

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 2207

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
John S. Feaster Sr				Aug 26 1987 11 45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
M	Black	MONTH DAY YEAR		79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S.C	USA			Baltimore City MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Loch Raven Veterans A. H.		Retired		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md		Baltimore	13e. STREET ADDRESS / ZIP CODE 21216		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
John Feaster		Katie Crosby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		237-01-8707		John Feaster, Jr 2603 Lyndhurst Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) SARCOMA Gastric Cancer					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Aug 25, 19 87, to Aug 26, 19 87, that (I) (we) lost saw the deceased (I) (we) did (I) (we) did not view the body after death.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8/31/87		Garrison Forest Vet	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H West 4300 Wabash Avenue		AUG 31 1987		Julia Swenson-Rudman	

MEDICAL CERTIFICATION

084242 SEP-58

AUG 31 1958

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

062377

FOR
STATE
REGISTER

AUG 11 1987

REG. NO.

22672

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROBERT MIDDLE: C. LAST: FELTER			2a. DATE OF DEATH MONTH: 8 DAY: 14 YEAR: 87 2b. HOUR: 5:38 M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH: 11 DAY: 23 YEAR: 34		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS IF UNDER 1 YEAR: MONTHS: DAYS: IF UNDER 74 HRS: HOURS: MIN:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Self Employed
13a. STATE Md.			13b. COUNTY ---	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST: UNKNOWN MIDDLE: --- LAST: Felter			15. MOTHER'S MAIDEN NAME FIRST: Catherine MIDDLE: --- LAST: Woods		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-30-6149		17. INFORMANT, ADDRESS Robert M. Felter, 1610 Popland Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a IDDM					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/11, 19 87, to 9/4, 19 87, that (I) (we) last saw the deceased alive on 8/4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE over s. Hersh MD				22c. DATE SIGNED Aug 5, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVA S. HERSH MD				22e. ADDRESS Deaton Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/7/87	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN: Elkridge COUNTY: Howard STATE: Maryland
24. FUNERAL DIRECTOR Hubbard Funeral Home, Inc., 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR AUG 07 1987	25b. REGISTRAR'S SIGNATURE Julia Dender-Rodden	

002377 AUG 11 87

100-0-1 881

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				22673 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) F LIZZIE FENNER				2a. DATE OF DEATH MONTH DAY YEAR 8 21 87			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 18 95		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTTICEY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST NED WINSTEAD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN EDWARDS		16. SOCIAL SECURITY NO. 242-14-6244			
17. INFORMANT Balto., Md. 1231		18. ADDRESS MARIE BROIDY 209 N. Bethel St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) POST CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF STROKE (L) AKA (c) STROKE (L) AKA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 1 Hour			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PERIPHERAL VASCULAR DISEASE, S/P MULTIPLE CVA's							
19a. DATE OF OPERATION 8/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE (L) FOOT		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUG 21, 19 87 to AUG 21, 19 87 that (I) (we) lost saw the deceased alive on AUG 21, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Steven Ahkendorf				DEGREE MD		22c. DATE SIGNED 8/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN AHKENDORF				22e. ADDRESS F.S. KEY HOSPITAL, BALTIMORE, MD			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8-26-1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.				25. DATE REC'D. BY REGISTRAR AUG 25 1987		25b. REGISTRAR'S SIGNATURE Julia Denson-Rodgers	

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003880 AUG 25 67

Handwritten notes and stamps, including a circular stamp on the right side of the page.

AUG 25 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the medical examiner.

064146 AUG 31 1987

FOR
STATE
DEPARTMENT OF HEALTH AND MENTAL HYGIENESTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22674

1. DECEASED NAME (TYPE OR PRINT) FIRST: ESTON P. LAST: TENWICK			2a. DATE OF DEATH MONTH: 08 DAY: 23 YEAR: 87 HOUR: 1:45 P.M.		
3. SEX F	4. RACE Caucasian	5. DATE OF BIRTH MONTH: 08 DAY: 22 YEAR: 1945	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7b. HOUR 1:45 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN) KENTUCKY	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F. LORD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland 13b. COUNTY: Baltimore 13c. CITY OR TOWN: Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST: LEE MIDDLE: LAST: PERKINS			15. MOTHER'S MAIDEN NAME FIRST: SAMANTHA MIDDLE: LAST: GOOD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT ADDRESS: VICKY HENRY 2309 LINCOLN AVE. 21219		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 912 RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) LOBAR PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dementia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 01/30/84, 19 84, to 08/23, 19 87, that (I) (we) lost saw the deceased alive on 08/23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Specialist		DEGREE MD PGY2		22c. DATE SIGNED 08/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GIORGIO GALETTO		22e. ADDRESS FRANCIS SCOTT KEY MED CENTER, DEPT. OF MEDICINE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/27/1987	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN: BALTO COUNTY: MD	
24. FUNERAL DIRECTOR NAME: CONNELLY FUNERAL HOME OF DUNDALK ADDRESS:		25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE J. Anderson-Randall	

BP.

TO IE 30A 3 4 1 4 20

064799 SEP 4 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This death certificate should be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate and page 2 should be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked on item 18 shows any injury, accident, or removal, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22675

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JASON IAN FETTERS		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30, 1987		2b. HOUR 1205P_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 11 76	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BALTIMORE CITY	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Richard W. Feters		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karen Lynn Short		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO.		17. INFORMANT Richard W. Feters Silver Spring, Md. 20904		17. ADDRESS 12415 Loft Lane 20904	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) organ failure liver/kidney DUE TO, OR AS A CONSEQUENCE OF: (c) recurrent hepatocellular carcinoma					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: S/P orthotopic liver transplant S/P resection of recurrent liver tumor					
19a. DATE OF OPERATION 7/16/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent tumor		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/16/87 P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. certify that (I) (this hospital) attended the deceased from 7/16/87 , 19 87 , to 8/30 , 19 87 , that (I) (we) last saw the deceased alive on August 30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22b. SIGNATURE Paul M. Colombani MD		22c. DEGREE MD		22d. DATE SIGNED 8/30/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL M. COLOMBANI		22f. ADDRESS 600 N Wolfe st The Johns Hopkins Hosp BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/87		23c. NAME OF CEMETERY OR CREMATORY Green Hill	
23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Green Penna.		24. FUNERAL DIRECTOR NAME HARRY H. WITZKE 4112 Columbia Rd. Ellicott City, Md. 21043			
25a. DATE REC'D. BY REGISTRAR SEP 3 1987		25b. REGISTRAR'S SIGNATURE Julia Swenson-Randall			

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063332 AUG 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22070
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FLORENCE COOPER FIBUS			2a. DATE OF DEATH MONTH DAY YEAR 8/14/87		2b. HOUR 12:27 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 1, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84
7a. BIRTHPLACE W. VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS COOPER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ABEL		16. SOCIAL SECURITY NO. 215-56-6098		
17. INFORMANT MRS. EDITH DANKER		18. ADDRESS 14401 OLD YORK RD. PHOENIX, MD 21131				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTICEMIA</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CACHEXIS, MALNUTRITION</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 8/13/87 to 8/14/87, and that in my opinion death occurred on the date and hour and from the causes noted above, (2) (a) (b) (c) did not view the body after death.						
22b. SIGNATURE Stuart B. Bell		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STUART B. BELL		22e. ADDRESS 3501 St. Paul				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rodach

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

003333 AUG 31 81



003333 AUG 31 81

064326 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22677
22677
REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST ANDREA	MIDDLE Janine	LAST FIELDS	2a. DATE OF DEATH MONTH DAY YEAR AUGUST 27, 1987	2b. HOUR 12:05P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 20 60		6. AGE (IN YEARS (LAST BIRTHDAY)) 27 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY St. Francis
13a. STATE Md		13b. COUNTY Balto.	13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2618 Hallam Ct. 21207		
14. FATHER'S NAME FIRST MIDDLE LAST Nicola Tranchitella		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willia Vanatta		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 213-80-8520		17. INFORMANT ADDRESS Mark Fields 2618 Hallam Ct. 21207						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) renal and hepatic failure								5 days
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic myelogenous leukemia								1 year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/10, 19 87, to 8/27, 19 87, that (I) (we) last saw the deceased alive on 8/27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE [Signature] MD		DEGREE MD					22c. DATE SIGNED 8/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUZANNE J. KOVEN MD		22e. ADDRESS JOHNS HOPKINS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/87	23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clarksville Md.			
24. FUNERAL DIRECTOR Harry H. Witzke		4112 Columbia Pike		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 31 1987 [Signature]				
Funeral Home, Inc.		Ellicott City, Md.		21043				

Table 1

1996-1997

Abstract

1114 *Alcedinca*

6454

063046 AUG 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22678

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEATRICE FIELDS			2a. DATE OF DEATH MONTH DAY YEAR 8 10 87			2b. HOUR MIN. 11 15	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 14 09		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry W.B. Jordan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Parks		16a. STREET ADDRESS / ZIP CODE 1815 W. Saratoga St. 21223			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-36-7758		17. INFORMANT Mildred Hicks		17. ADDRESS 3901 Conshohocken Ave. Phila, Pa	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy, aneur DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Apex of bleeding -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a SEPSIS - CHRONIC RENAL FAILURE - DECUBITUS, PARANAIL							
19a. DATE OF OPERATION 7/23/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Debridement Decubitus ul		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/23/87 19 to 8/10/87 19, that (I) (we) last saw the deceased alive on 8/10/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE PHYSICIAN		22c. DATE SIGNED 8/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. E. CORREN				22e. ADDRESS LIBERTY MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/15/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H West 4300 Wabash Ave.				25a. DATE REC'D. BY REGISTRAR AUG 17 1987		25b. REGISTRAR'S SIGNATURE Julia Tindem-Rodwell	

003018 AUG 18 81

063969 AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22679
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RAYMOND FINCHAM, SR.			2a. DATE OF DEATH MONTH DAY YEAR 8-24-87			2b. HOUR 16:55 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 1 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur			12b. KIND OF BUSINESS OR INDUSTRY Standard Supply Co.		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 1056 Parksley Avenue 21223		
14. FATHER'S NAME FIRST MIDDLE LAST Earnest Fincham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Corbin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Betty J. Fincham		17. ADDRESS 1056 Parksley Ave. 21223				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 24</u> 19 <u>87</u> to <u>Aug 24</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Aug 24</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Clara Massey, M.D.</u>		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Clara V. Massey</u>		22e. ADDRESS <u>Univ. of Maryland - Dept. of Cardiology</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/27/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Va. Cem. Owings Mills Balto. Md		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pudney</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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064401 SEP 1 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22680

1. DECEASED NAME
(TYPE OR PRINT)

CHARLES E. FISHER, Sr.

2a. DATE OF DEATH MONTH DAY YEAR 8-28-87 2b. HOUR 9:55 AM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR 11 12 12

6. AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Levindale Hebrew Geriatric Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY

13c. CITY OR TOWN Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3801 Roland Avenue 21211

14. FATHER'S NAME

Elmer

MIDDLE

T.

LAST

Fisher

15. MOTHER'S MAIDEN NAME

Nettie

MIDDLE

(unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

--

16b. SOCIAL SECURITY NO.

217-07-9664

17. INFORMANT

ADDRESS

Nettie M. Fisher 3801 Roland Avenue 21211

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

COPD Lung with wide

DUE TO, OR AS A CONSEQUENCE OF

(b) Spread metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/22 1987, to 8-28 1987, that (I) (we) lost saw the deceased alive on 8-28 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8-28-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

B. NAW-W. N. MD

22e. ADDRESS

Levindale Geriatric Ctr 21215

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/31/87

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Cemetery

23d. LOCATION CITY OR TOWN

Baltimore

COUNTY

Maryland

24. FUNERAL DIRECTOR

NAME

ADDRESS

A. Alan Seitz, Jr. 3818 Roland Ave. 21211

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

AUG 31 1987

Julia Anderson-Randall

004401 SEP-10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22681
REG. NO.FOR
1. STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) WALTER FITZGERALD			2a. DATE OF DEATH MONTH 08 DAY 30 YEAR 87			2b. HOUR M			
3. SEX m		4. RACE B		5. DATE OF BIRTH MONTH 7 DAY 12 YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 710 E. CHASE STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION WK		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 710 E. CHASE STREET 21202	
14. FATHER'S NAME FIRST MAC MIDDLE LAST FITZGERALD		15. MOTHER'S MAIDEN NAME FIRST KELLO MIDDLE LAST FITZGERALD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-07-2686A		17. INFORMANT ADDRESS BERNARD BROWN JR. 1245 GLENEAGLE ROAD 21239					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS 4 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY TUBERCULOSIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 		CITY OR TOWN 		COUNTY STATE 	
22a. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 87 , to 8/30 , 19 87 , that (I) (we) lost saw the deceased alive on 8/14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donna C. Phillips MD						DEGREE 		22c. DATE SIGNED 8/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONNA C.P. PHILLIPS MD						22e. ADDRESS 301 ST PAUL PL BALT, MD 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/5/87		23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY		23d. LOCATION CITY OR TOWN LANDSDOWNE		COUNTY STATE MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE 21202						25a. DATE REC'D. BY REGISTRAR SEP 4 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18 E-932 03042

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

#18, FilmG633 11/20/87 kam		STATE OF MARYLAND 87 22682	
1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
#18, FilmG634 12/16/87ja		CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		7a. DATE OF DEATH MONTH DAY YEAR	
FIRST MIDDLE LAST		2b. HOUR	
Julius Shelton Flemming, Sr		Aug. 15, 1987 5:12 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)
male	black	04 / 10 / 18	69 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Balto. City MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Deaton Hospital & Medical Center	Mail Carrier	U. S. Postal
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland		Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	13e. STREET ADDRESS / ZIP CODE	
Shelton Flemming	Sophie Ringgald	611 Grantley St. 21229	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	220-03-9833	Mrs. Frances Flemming 611 Grantley St. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Laryngeal Carcinoma</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>laryngo-tracheal damage</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>laryngeal carcinoma</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/27/1987 to 8/15/1987, that (I) (we) last saw the deceased alive on 8/15/1987, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Eva S. Hersh MD</u> DEGREE			22c. DATE SIGNED 8/15/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EVA S. HERSH MD</u>			22e. ADDRESS <u>DEATON HOSPITAL</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	19 Aug 87	New Cathedral Cemetery	Baltimore Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy		AUG 21 1987	
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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064168 AUG 31 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22083
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director is to file a copy of this certificate with the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) Lynwood Fleming			2a. DATE OF DEATH MONTH DAY YEAR 8-23-87		2b. HOUR 8 P.M.	
3. SEX M	4. RACE WIK	5. DATE OF BIRTH MONTH DAY YEAR 30 5-20		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Salt City MD.		
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason F. Lord N.H.		12a. USUAL OCCUPATION / (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW FLEMING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HOPSON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 145-12-5909		17. INFORMANT ADDRESS FLORENCE FLEMING 111 CENTER STREET 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Status Epilepticus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HTN -						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-23-87 to 8-23-87 , that (I) (we) last saw the deceased alive on 8-23-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE [Signature]		22c. DATE SIGNED 8-24-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett		22e. ADDRESS 5200 Eastern Ave Balto 21224				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/28/87	23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETERY		23d. LOCATION BALTIMORE COUNTY STATE MD		
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H 1101 E. NORTH AVENUE 21202		25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22684
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
CHARLES HOWARD FLETCHER								AUG 28, 1987								M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		NEGRO		7-7-07		80		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		U.S.A.				BALTIMORE CITY										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE		814 HARLEM AVE		RETIRED													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
MARYLAND				BALTIMORE				814 HARLEM AVE 21201									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
EDWARD		H.		FLETCHER		ANBERTA		THOMAS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		W. W. II		215 10 0993		McCHARLES H. FLETCHER		3307 ROLLING ROAD		21201							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
				cardiac arrest		hypertension											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 9-14, 1986, to 8-28, 1987, that (I) (we) last saw the deceased alive on 8-27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
M. Rudikoff		222 Wild Spring Baltimore															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		9-2-87		ABUTUS MEM PARK		BALTO CO MD											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
JOSEPH L. RUSS		2222 W. NORTH AVE		AUG 31 1987		Julia Gordon-Rudner											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must have carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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62296 AUG 11 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22085

REG. NO.

1- DECEASED NAME (TYPE OR PRINT) ANITA		Fogarty		2a DATE OF DEATH MONTH DAY YEAR 8 8 87		2b HOUR 11: 7 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 8 98		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. JENKINS MEMORIAL HOME (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 S. Caton Ave. 21229		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY --	
13a STATE Maryland		13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Owen		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Christian		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b SOCIAL SECURITY NO. 217-01-4698		17. INFORMANT ADDRESS Jenkins Mem. Home 1000 S. Caton Ave. 21229					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>yes</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-8-87</u> to <u>8-8-87</u> , that (we) lost the deceased alive on <u>8-8-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.							
22b. SIGNATURE Lawrence R. Gallager MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		TR. DATE SIGNED 8-8-87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence R. Gallager				22e. ADDRESS 1000 S. Caton Avenue			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION Baltimore COUNTY Maryland	
24. FUNERAL DIRECTOR Hubbard funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE Julia Swinson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22686

1. DECEASED NAME (TYPE OR PRINT) EDNA R. FORD			2a. DATE OF DEATH MONTH DAY YEAR 8 30 87			2b. HOUR 11:15AM				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 10 98		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levin Oak Hebrew Geriatric Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3915 Calloway Ave 21215	
14. FATHER'S NAME FIRST MIDDLE LAST George Buchanan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 212-767463		17. INFORMANT Russell Ford 3018 Mondawmin Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/30 19 87 to 8/30 19 87 that (I) (we) lost saw the deceased alive on 8/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Zawhara, MD			22e. ADDRESS Levin Oak Geriatric Gr 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/3/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY Baltimore MD			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue						25a. DATE REC'D. BY REGISTRAR SEP 2 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the State Department must be notified at once.

BP

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(VRA 15, 4)

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22687

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			MONTH DAY YEAR			2b HOUR					
Darlene			Forehand			8 24 19 87			8 24 19 87			M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD		2d HOUR			
female		black		11 9 1957		29 YRS.		MONTHS DAYS		HOURS MIN.		8 24 19 87		6:05 PM			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH					
Md				U S A								Baltimore City MD					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY					
Baltimore				Bon Secours Hospital				Unemployed									
13a STATE												13b COUNTY		13c INSIDE CITY LIMITS?		13d STREET ADDRESS	
Md														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		541 N. Fulton Avenue 21223	
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Thomas Henry Forehand						Susie Shaw											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b SOCIAL SECURITY NO.						17 INFORMANT ADDRESS					
No						218-62-9641						Susie Forehand 541 N. Fulton Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?			
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION									
								STREET CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED					
Mario F. Golle, Jr.				M.D. Assistant MEDICAL EXAMINER								8-25-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Mario F. Golle, Jr., M.D.				111 Penn St., Balto., MD 21201													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION							
Burial				8/29/87		Mt Zion Cemetery				Landsdown							
										COUNTY STATE							
										MD							
24 FUNERAL DIRECTOR								25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
NAME ADDRESS																	
Wm. C. March F/H West 4300 Wabash Avenue												AUG 27 1987 Julia Davidson					

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BP

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AUG 31 1982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 2 2 6 8 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Baby Boy Forrest			2a. DATE OF DEATH MONTH DAY YEAR 8 27 87		2b. HOUR 11:58 PM
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 27 87	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 8 27 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
11. CITY OR TOWN OF DEATH Baltimore City	10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 99999	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL FORREST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANNIA FORREST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>premature labor and delivery</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>maternal apparent chorioamnionitis</u>					
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> , 19 <u>87</u> , to <u>8/27</u> , 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>8/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>B. M. Starr</u>		DEGREE MD		22c. DATE SIGNED 8/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barnaby Starr, M.D.		22e. ADDRESS The Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 9-3-87	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR SEP 9 1987	
		25b. REGISTRAR'S SIGNATURE <u>J. J. Starr</u>			

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063516 AUG 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 6 8 9
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAURICE J. FOWLER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 19, 1987		2b. HOUR 5:30AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 7 1914		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beth Steel		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.			13b. COUNTY Balto.	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST William J. Fowler			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Sheridan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 207-01-6037		17. INFORMANT ADDRESS Catherine Henderson 305 Broxton Rd. 21212	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF, (b) BOWEL, OMENTUM METASTATIC CANCER OF SMALL INTESTINE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, (c) RENAL CELL CANCER (SARCOMATOUS TYPE)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 6, 1987 , to AUGUST 19, 1987 , that (I) (we) lost saw the deceased alive on AUGUST 19, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>M. S. Puri</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURARI BIJPURIA M. D.		22e. ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTIMORE, MD. 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/1987	23c. NAME OF CEMETERY OR CREMATORY All Hallows		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville Md.
24 FUNERAL DIRECTOR NAME Connelly Funeral Home of Dundalk		ADDRESS Dundalk		25a. DATE REC'D. BY REGISTRAR AUG 21 1987	25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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064000 AUG 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22090

1. DECEASED NAME (TYPE OR PRINT) CHRISTINE E. FOWLES			2a. DATE OF DEATH MONTH DAY YEAR 8/21/87		2b. HOUR M M
3. SEX FEMALE	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 3/9/1909		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BURNSWICK, VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1022 MC DONALD ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PARHAM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELIA FEGGANS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A		16b. SOCIAL SECURITY NO. 220-01-1025	17. INFORMANT ADDRESS DORIS BURRIS 1417 E. LANVALE 21213		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Severe Hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 6 months 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July , 19 85 , to August , 19 87 , that (I) (we) last saw the deceased alive on June 9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Susan M. Melley		DEGREE MD		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan M. Melley		22e. ADDRESS The Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/26/87	23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.	
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HEIGHTS		ADDRESS 4600 LIBERTY HEIGHTS		25a. DATE REC'D. BY REGISTRAR AUG 26 1987	
				25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15. 4)

DECEASED NAME ROBERT J. FOX		FIRST J.		MIDDLE FOX		LAST FOX		2a. DATE OF DEATH 8/19/87		MONTH 8		DAY 19		YEAR 1987		2b. HOUR 2:22 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH Jan. DAY 3, YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN. 0		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md.		12b. COUNTY Baltimore		12c. CITY OR TOWN Baltimore		12d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12e. STREET ADDRESS / ZIP CODE 3501 St. Paul St. 21218		12f. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12g. KIND OF BUSINESS OR INDUSTRY West. Electric		12h. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		12i. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			
13a. FATHER'S NAME FIRST Edward MIDDLE J. LAST Fox		13b. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE Hancock LAST Hancock		13c. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		13d. SOCIAL SECURITY NO. 216 01 9280		13e. INFORMANT Mrs. Clara M. Fox		13f. ADDRESS 3501 St. Paul St. -18		13g. DATE OF OPERATION 8/19/87		13h. CONDITION FOR WHICH OPERATION WAS PERFORMED ② HIP FRACTURE		13i. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13j. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 888 IMMEDIATE CAUSE (a) SUDDEN CARDIAC ARREST		14a. DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS		14b. DUE TO, OR AS A CONSEQUENCE OF (c) ② HIP FRACTURE		14c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		14d. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ② HIP FRACTURE		14e. DATE OF OPERATION 8/19/87		14f. CONDITION FOR WHICH OPERATION WAS PERFORMED ② HIP FRACTURE		14g. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14h. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		14i. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
14j. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		14k. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:00 PM 8/17/87		14l. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL TO FLOOR IN APT.		14m. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME		14n. LOCATION STREET 3501 ST. PAUL ST. CITY OR TOWN BALTIMORE COUNTY M.D. STATE MD		14o. I certify that (1) if this hospital attended the deceased from above, (1) well and (2) did not view the body after death.		14p. SIGNATURE Paul Cooper		14q. DEGREE M.D.		14r. CERTIFICATION APPROVED BY ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		14s. DATE SIGNED 8/19/87	
14t. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL COOPER		14u. ADDRESS M.D. 201 E. UNIVERSITY PKWY / BALT, M.D.		14v. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		14w. DATE 8/22/87		14x. NAME OF CEMETERY OR CREMATORY Dulaney Valley		14y. LOCATION CITY OR TOWN Timonium, Md. COUNTY M.D. STATE MD		14z. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC.		14aa. ADDRESS 6500 York Rd.		14ab. DATE REC'D. BY REGISTRAR AUG 26 1987		14ac. REGISTRAR'S SIGNATURE John Burden	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22092
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KURT ALAN FRANK			2a. DATE OF DEATH MONTH DAY YEAR 8 31 87			2b. HOUR 5:20 P	
3. SEX M		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 7 30 55		6. AGE (IN YEARS LAST BIRTHDAY) 32	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSP. MIENAS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF Employed		12b. KIND OF BUSINESS OR INDUSTRY PHOTOGRAPHER	
13a. STATE md.		13b. COUNTY TOWSON		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT J. FRANK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOLA R. REED		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 216-76-8323	
17. INFORMANT Robert J. Frank		18. ADDRESS 927 CROMWELL Bridge Rd.		19. CITY OR TOWN BALTO.		20. STATE MD.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 Hour

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) Immobilization, post cerebral aneurysm surgery

DUE TO, OR AS A CONSEQUENCE OF

(c) post Intracerebral hemorrhage 8/17/87

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Intracerebral hemorrhage 8/17/87

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	---	---

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
--	--	---

22a. I certify that (I) (this hospital) attended the deceased from 8/17, 19 87, to 8/31, 19 87, that (I) (we) last saw the deceased alive on 8/31, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Stephen D. Campbell, MD</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>8/31/87</u>
--	---------------------	--	------------------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen D. Campbell, MD</u>	22e. ADDRESS <u>1401 Belair Rd. BALTO. MD. 21236</u>
---	---

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-3-87	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
---	----------------------------	--	--

24. FUNERAL DIRECTOR NAME Lassahn Funeral Home	25a. DATE REC'D. BY REGISTRAR SEP 02 1987	25b. REGISTRAR'S SIGNATURE <u>John Swickard</u>
---	---	--

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

084821 SEP-301

REMARKS

TIME

DATE

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

SEP03 001

064473 SEP-28

Item 1, FilmG631, 9-3-87, J. I. STATE OF MARYLAND

FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 6 9 3

1. DECEASED NAME (PRINT) Charles JOSEPH Freeburger		2a. DATE KNOWN OF DEATH 8 30 19 87		2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 19, 1907	6. AGE (IN YEARS) 80 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital (DOA)	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Clerk-Glenn L. Martin		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	
13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 5405 Grindon Ave. 21214		14. FATHER'S NAME FIRST William MIDDLE S. LAST Freeburger		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE T. LAST Edelman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-4066		17. INFORMANT ADDRESS 21204 608 Mr. Jerry Ruzicka 3 Southerly Ct. Apt.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 8-31-87	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-87		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	
23d. LOCATION CITY OR TOWN Baltimore, Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR SEP 1 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pulaski</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 2. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/BA
25AM

BP

DHMH - 17
(VR A15 ME (5))

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NOTICE

Continued

Continued

Continued

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 2 0 9 4
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY LEROY FREELAND			2a. DATE OF DEATH MONTH DAY YEAR 08/06/87		2b. HOUR 6:43 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11/03/15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PUB. ENG.		12b. KIND OF BUSINESS OR INDUSTRY BLACK & OSTER
13a. STATE Maryland		13b. COUNTY BALTIMORE	13c. CITY OR TOWN PARKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN OLIVER FREELAND		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA MAY NACE		13e. STREET ADDRESS / ZIP CODE 8310 BERYL ROAD 21234	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212109699		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from <u>7/21</u> 19 <u>87</u> to <u>8/6</u> 19 <u>87</u> , that I (we) last saw the deceased alive on <u>8/6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (do not) view the body after death.					
22b. SIGNATURE <i>F. Khawli</i>				22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FADI KHAWLI				22e. ADDRESS GOOD SAMARITAN HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 8, 1987	23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE TIMONIAN BALTO MD
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES ROAD		25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22095

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

JOSEPH

FREET

2a. DATE OF DEATH

MONTH

DAY

YEAR

AUGUST 14, 1987

2b. HOUR

8:00 PM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

2 25 07

6. AGE (IN YEARS LAST BIRTHDAY)

80

YRS

7. UNDER 1 YEAR

MONTHS

DAYS

8. UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1314 Easton Pl.
Key Circle Hospice 21217

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

216-28-9662

17. INFORMANT

ADDRESS

Teresa Jeter 1114 Cathedral Street

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

PERIPHERAL VASCULAR DISEASE, DEMENTIA

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (the hospital) attended the deceased from AUGUST 14, 19 87, to AUGUST 14, 19 87, that (I) (we) last saw the deceased alive on AUGUST 14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8/14/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

THOMAS AHN

22e. ADDRESS

CHURCH HOSPITAL CORPORATION

100 N. BROADWAY BALTIMORE, MD. 21231

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/21/87

23c. NAME OF CEMETERY OR CREMATORY

Sacret Heart off Jesus Balto. Co.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

Chatman-Harris FH 1701 McCulloh Street

25a. DATE REC'D. BY REGISTRAR

AUG 25 1987

25b. REGISTRAR'S SIGNATURE

Julia Sanders-Rudolph

99
35
300
1

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma to the event, the medical examiner must be notified of same.

BP

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062910 AUG 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG 2. 6 9 6

1 DECEASED NAME (TYPE OR PRINT) Marie E. Gotshall		2a DATE KNOWN OF DEATH 8-5-87		2b HOUR 6:55P	
3 SEX Female		4 RACE White		5 DATE OF BIRTH Sept. 28 1911	
6 AGE (IN YEARS) 75		7 IF UNDER 1 YR. NO		8 IF UNDER 24 HRS. NO	
9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10 CITIZEN OF WHAT COUNTRY? USA		11 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
12 CITY OR TOWN OF DEATH Baltimore		13 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Francis Scott Key Medical Center		14 USUAL OCCUPATION (TYPE OF WORK OR FACT OF WORKING LIFE) Cook	
15 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		16 COUNTY Baltimore		17 CITY OR TOWN Dundalk	
18 INSIDE CITY LIMITS? YES		19 STREET ADDRESS 7814 New Battle Grove Rd.		20 ZIP CODE 21222	
21 FATHER'S NAME Edward Clayton		22 MOTHER'S MAIDEN NAME Bertha Carter		23 ADDRESS Same	
24 WAS DECEASED EVER IN U.S. ARMED FORCES? NO		25 SOCIAL SECURITY NO. 212 20 9123		26 INFORMANT Leroy F. Gotshall, Husband	
27 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
28 DATE OF OPERATION		29 CONDITION FOR WHICH OPERATION WAS PERFORMED?		30 AUTOPSY? YES	
31a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		31b TIME OF INJURY 19		31c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
32a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		32b PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		32c LOCATION 111 Penn Street	
33 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
34 ACTUAL SIGNATURE Margarita A. Korell		35 TITLE (SPECIFY) Assistant		36 DATE SIGNED 8-6-87	
37 EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		38 ADDRESS 111 Penn Street		39	
40 BURIAL, CREMATION, REMOVAL Burial		41 DATE 8/8/87		42 NAME OF CEMETERY OR CREMATORY Crest Lawn Memorial Pk.	
43 LOCATION Howard Co., Md.		44 DATE REC'D. BY REGISTRAR AUG 7 1987		45 REGISTRAR'S SIGNATURE John F. ...	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH OTHER PAGES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22697

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Nathaniel B. Frey Jr.

2a. DATE OF DEATH MONTH DAY YEAR

8/25/87

2b. HOUR 2:01 P.M.

3. SEX

Male

4. RACE

C 1

5. DATE OF BIRTH

01-15-14

6. AGE (IN YEARS LAST BIRTHDAY)

73

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto. City

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

BALT City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Mercy Hospital

12a. USUAL OCCUPATION

Accountant-Ret.

12b. KIND OF BUSINESS OR INDUSTRY

State of MD

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Balto. City

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2 Charles Ctr. Apt. 1102 North

14. FATHER'S NAME

Nathaniel

MIDDLE

B.

LAST

Frey, Sr.

15. MOTHER'S MAIDEN NAME

Ilena Gale

Balto., MD 21201

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

217077676

17. INFORMANT

ADDRESS

Virginia M. Frey, 2 Charles Ctr. Apt. 1102

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerotic coronary artery disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHITE ☐ AT WORKNOT WHILE ☐ AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/25/87 to 8/25/87 that (I) (we) last saw the deceased alive on 8/25/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Louis E. Grenzier

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8/25/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Louis E. Grenzier

22e. ADDRESS

1101 N. Calvert St.

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

8-28-87

23c. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

23d. LOCATION

Balto.

COUNTY Balto., STATE MD

24. FUNERAL DIRECTOR

John C. Miller, Inc., 6415 Belair Rd. 21206

25a. DATE RECEIVED BY REGISTRAR

AUG 28 1987

25b. REGISTRAR'S SIGNATURE

John C. Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-1127 781130
MAY 31 85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 6 7 8

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

EVA

FREYER

2a. DATE OF DEATH MONTH DAY YEAR
AUGUST 30, 19872b. HOUR P
5:10 M

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

AUGUST 3, 1895

6. AGE (IN YEARS LAST BIRTHDAY)

92

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

GERMANY

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY, MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

LONGGREEN NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4506 N. CHARLES ST. APT A 21210

14. FATHER'S NAME

MAX

MIDDLE

LICHTEINSTEIN

15. MOTHER'S MAIDEN NAME

JOHANNA

MIDDLE

SAMUEL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

213-34-9266

17. INFORMANT MRS. MARION WOLFF 5609 ROOSEVELT ST.

BETHESDA, MD (20817)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.10

glaucoma senile dementia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I (this hospital) attended the deceased from 8/30 1987 to 8/30 1987, that (I/we) last saw the deceased alive on 8/30 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (and) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8/31/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ALICIA COOL-FOLEY MD

22e. ADDRESS

201 E. UNIVERSITY PARKWAY

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL23b. DATE
9-1-8723c. NAME OF CEMETERY OR CREMATORY
CHEVRA ANAHS CHESSED23d. LOCATION
RANDALLSTOWN BALTO MARYLAND

24. FUNERAL DIRECTOR SOL LEVINSON & BROS 6010

REISTERSTOWN ROAD BALTIMORE, MD 21215

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

SEP 4 1987 Julia Tindler-Rudolph

00483 269-001

Approved and signed

John D. [illegible]

Witness my hand and seal this 1st day of [illegible]

John D. [illegible]

SEP 4 1932

063462 AUG 21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22097

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Fritz			2a. DATE OF DEATH MONTH DAY YEAR 8-11-87			2b. HOUR 9:40 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 27 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Allegheny PA		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		
12b. KIND OF BUSINESS OR INDUSTRY Sani-Dairy		13a. STATE PA						
13b. COUNTY Bedford		13c. CITY OR TOWN New Paris		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RD. Box 102, 15554		
14. FATHER'S NAME FIRST MIDDLE LAST William P. Harris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 168-50-1447		17. INFORMANT ADDRESS Jerry Fritz Sr. RD. Box 102, New Paris PA				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/11 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/5 19 87 , to 8/11 19 87 , that (I) (we) lost saw the deceased alive on 8/11 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Thomas OBrien				DEGREE MD		22c. DATE SIGNED 8/11/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas OBrien				22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/15/87		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Johnstown, Cambria PA		
24. FUNERAL DIRECTOR NAME Sendusaw F.H. Schuster				25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE Julia Finken-Rudner		

003405 AUG 51 01

20X6 COLLOID LITH

WHITTING

Antibiotic and

063617 AUG 25 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Charles

W.

Frye

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
8/ 13/19 87

2b. HOUR
M

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE

MONTH DAY YEAR

2d. HOUR

M

W

8 15 26

60 YRS.

MONTHS DAYS

HOURS MIN.

PRONOUNCED

8/ 13/19 87

10:12

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

2e. HOUR

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

8. MARRIED ☐ NEVER MARRIED ☐

Baltimore City,

MD

12a. USUAL RESIDENCE

(IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

100 W. West Street

12b. USUAL OCCUPATION

12c. KIND OF BUSINESS OR INDUSTRY

MD

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Street Person

MD

14a. FATHER'S NAME

14b. MOTHER'S MAIDEN NAME

14c. CITY OR TOWN

14d. INSIDE CITY LIMITS?

14e. STREET ADDRESS

14f. KIND OF BUSINESS OR INDUSTRY

MD

15a. WAS DECEASED EVER IN U.S. ARMED FORCES?

15b. SOCIAL SECURITY NO.

15c. INFORMANT

15d. ADDRESS

15e. OFFICER S.D. Suyhy

15f. SOUTHERN DISTRICT

MD

16a. CAUSE OF DEATH

16b. IMMEDIATE CAUSE (a)

16c. DUE TO, OR AS A CONSEQUENCE OF

16d. (b)

16e. DUE TO, OR AS A CONSEQUENCE OF

16f. (c)

MD

17a. PART 2 OTHER SIGNIFICANT CONDITIONS

CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

17b. DATE OF OPERATION

17c. CONDITION FOR WHICH OPERATION WAS PERFORMED?

17d. AUTOPSY?

17e. YES ☒ NO ☐

MD

18a. EXTERNAL CAUSE WAS

18b. TIME OF INJURY

18c. HOW INJURY OCCURRED

18d. PLACE OF INJURY

18e. LOCATION

18f. CITY OR TOWN

MD

19a. UNDERLYING

19b. OR CONTRIBUTING

19c. CAUSE OF DEATH

19d. PLACE OF INJURY

19e. LOCATION

19f. CITY OR TOWN

MD

20a. I certify that I took charge of the remains described above, held on

20b. Autopsy ☒20c. Inspection ☐20d. Inquiry ☐

20e. and in my opinion

20f. death resulted from

MD

21a. Natural causes ☒21b. Accident ☐21c. Suicide ☐21d. Homicide ☐21e. Undetermined manner ☐

21f. Actual Signature

MD

22a. TITLE (SPECIFY)

22b. Assistant

22c. MEDICAL EXAMINER

22d. DATE SIGNED

22e. 8/13/87

22f. EXAMINER'S NAME

MD

23a. (TYPE OR PRINT)

23b. Dennis F. Smyth, M.D.

23c. ADDRESS

23d. 111 Penn St.

23e. 23a. BURIAL, CREMATION, REMOVAL

23b. DATE

MD

24a. REMOVAL

24b. 8-19-87

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION

24e. CITY OR TOWN

24f. COUNTY

MD

25a. FUNERAL DIRECTOR

25b. NAME

25c. ADDRESS

25d. State Anatomy Board

25e. Balto., Md.

25f. DATE REC'D BY REGISTRAR

MD

26a. REGISTRAR'S SIGNATURE

26b. DATE

26c. REGISTRAR'S SIGNATURE

26d. DATE

26e. REGISTRAR'S SIGNATURE

26f. DATE

MD

27a. REGISTRAR'S SIGNATURE

27b. DATE

27c. REGISTRAR'S SIGNATURE

27d. DATE

27e. REGISTRAR'S SIGNATURE

27f. DATE

MD

28a. REGISTRAR'S SIGNATURE

28b. DATE

28c. REGISTRAR'S SIGNATURE

28d. DATE

28e. REGISTRAR'S SIGNATURE

28f. DATE

MD

29a. REGISTRAR'S SIGNATURE

29b. DATE

29c. REGISTRAR'S SIGNATURE

29d. DATE

29e. REGISTRAR'S SIGNATURE

29f. DATE

MD

30a. REGISTRAR'S SIGNATURE

30b. DATE

30c. REGISTRAR'S SIGNATURE

30d. DATE

30e. REGISTRAR'S SIGNATURE

30f. DATE

MD

31a. REGISTRAR'S SIGNATURE

31b. DATE

31c. REGISTRAR'S SIGNATURE

31d. DATE

31e. REGISTRAR'S SIGNATURE

31f. DATE

MD

32a. REGISTRAR'S SIGNATURE

32b. DATE

32c. REGISTRAR'S SIGNATURE

32d. DATE

32e. REGISTRAR'S SIGNATURE

32f. DATE

MD

33a. REGISTRAR'S SIGNATURE

33b. DATE

33c. REGISTRAR'S SIGNATURE

33d. DATE

33e. REGISTRAR'S SIGNATURE

33f. DATE

MD

34a. REGISTRAR'S SIGNATURE

34b. DATE

34c. REGISTRAR'S SIGNATURE

34d. DATE

34e. REGISTRAR'S SIGNATURE

34f. DATE

MD

35a. REGISTRAR'S SIGNATURE

35b. DATE

35c. REGISTRAR'S SIGNATURE

35d. DATE

35e. REGISTRAR'S SIGNATURE

35f. DATE

MD

36a. REGISTRAR'S SIGNATURE

36b. DATE

36c. REGISTRAR'S SIGNATURE

36d. DATE

36e. REGISTRAR'S SIGNATURE

36f. DATE

MD

37a. REGISTRAR'S SIGNATURE

37b. DATE

37c. REGISTRAR'S SIGNATURE

37d. DATE

37e. REGISTRAR'S SIGNATURE

37f. DATE

MD

38a. REGISTRAR'S SIGNATURE

38b. DATE

38c. REGISTRAR'S SIGNATURE

38d. DATE

38e. REGISTRAR'S SIGNATURE

38f. DATE

MD

39a. REGISTRAR'S SIGNATURE

39b. DATE

39c. REGISTRAR'S SIGNATURE

39d. DATE

39e. REGISTRAR'S SIGNATURE

39f. DATE

MD

40a. REGISTRAR'S SIGNATURE

40b. DATE

40c. REGISTRAR'S SIGNATURE

40d. DATE

40e. REGISTRAR'S SIGNATURE

40f. DATE

MD

41a. REGISTRAR'S SIGNATURE

41b. DATE

41c. REGISTRAR'S SIGNATURE

41d. DATE

41e. REGISTRAR'S SIGNATURE

41f. DATE

MD

42a. REGISTRAR'S SIGNATURE

42b. DATE

42c. REGISTRAR'S SIGNATURE

42d. DATE

42e. REGISTRAR'S SIGNATURE

42f. DATE

MD

43a. REGISTRAR'S SIGNATURE

43b. DATE

43c. REGISTRAR'S SIGNATURE

43d. DATE

43e. REGISTRAR'S SIGNATURE

43f. DATE

MD

44a. REGISTRAR'S SIGNATURE

44b. DATE

44c. REGISTRAR'S SIGNATURE

44d. DATE

44e. REGISTRAR'S SIGNATURE

44f. DATE

MD

45a. REGISTRAR'S SIGNATURE

45b. DATE

45c. REGISTRAR'S SIGNATURE

45d. DATE

45e. REGISTRAR'S SIGNATURE

45f. DATE

MD

46a. REGISTRAR'S SIGNATURE

46b. DATE

46c. REGISTRAR'S SIGNATURE

46d. DATE

46e. REGISTRAR'S SIGNATURE

46f. DATE

MD

47a. REGISTRAR'S SIGNATURE

47b. DATE

47c. REGISTRAR'S SIGNATURE

47d. DATE

47e. REGISTRAR'S SIGNATURE

47f. DATE

MD

48a. REGISTRAR'S SIGNATURE

48b. DATE

48c. REGISTRAR'S SIGNATURE

48d. DATE

48e. REGISTRAR'S SIGNATURE

48f. DATE

MD

49a. REGISTRAR'S SIGNATURE

49b. DATE

49c. REGISTRAR'S SIGNATURE

49d. DATE

49e. REGISTRAR'S SIGNATURE

49f. DATE

MD

50a. REGISTRAR'S SIGNATURE

50b. DATE

50c. REGISTRAR'S SIGNATURE

50d. DATE

50e. REGISTRAR'S SIGNATURE

50f. DATE

MD

51a. REGISTRAR'S SIGNATURE

51b. DATE

51c. REGISTRAR'S SIGNATURE

51d. DATE

51e. REGISTRAR'S SIGNATURE

51f. DATE

MD

52a. REGISTRAR'S SIGNATURE

52b. DATE

52c. REGISTRAR'S SIGNATURE

52d. DATE

52e. REGISTRAR'S SIGNATURE

52f. DATE

MD

53a. REGISTRAR'S SIGNATURE

53b. DATE

53c. REGISTRAR'S SIGNATURE

53d. DATE

53e. REGISTRAR'S SIGNATURE

063817 W02 52 81

142
53

W02 54 80

062090 AUG 2 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22701
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MELVIN FULD		2a. DATE OF DEATH MONTH DAY YEAR AUG. 3, 1987		2b. HOUR 6:15P _M	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR JULY 18, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6317 PARK HEIGHTS AVE. #420 (21215)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPRIETOR		12b. KIND OF BUSINESS OR INDUSTRY FULD BROS. INC.
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST SOLOMON FULD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES ROMSHEIM		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 214-26-9743 A		17. INFORMANT ADDRESS MRS. CAROL P. FULD APT. 420 (21215) 6317 PARK HEIGHTS AVE.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBROVASCULAR DISEASE, PNEUMONIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the hospital attended the deceased from 8/3/87 to 8/3/87 and that (2) the deceased was seen alive on 8/3/87 and that (3) in my opinion death occurred on the date and hour and from the causes stated above, (4) I did view the body after death.					
22b. SIGNATURE Howard B. Chen		DEGREE M.D.		22c. DATE SIGNED 8/4/87	
22d. PHYSICIAN'S NAME (TYPE OF PRINT) HOWARD B. CHEN		22e. ADDRESS 6610 CROSS COUNTRY BLVD. BALTO., MD. (21215)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/5/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.		24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)			
25a. DATE REC'D. BY REGISTRAR AUG 5 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

107

005030 WNC-8 81

1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 1 2 2 7 0 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (LAST, FIRST, MIDDLE) ADOLPH FURMAN		2a. DATE OF DEATH MONTH DAY YEAR 8 18 87		2b. HOUR 9.15 A M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 3 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE		12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS FURMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE BLUM		16. SOCIAL SECURITY NO. 218-09-1307	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT ADDRESS EDWARD PATZ 15 EVAN WAY (21208)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-18-87 to 8-18-87 that (I) (we) lost saw the deceased alive on 8-18-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE SET H TWAR		DEGREE MD		22c. DATE SIGNED 8-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SET H TWAR		22e. ADDRESS LEVINDALE, 2434 BELVERDERE AVE BALTIMORE MD - 21215			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8/19/87	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215				25a. DATE REC'D. BY REGISTRAR AUG 25 1987 25b. REGISTRAR'S SIGNATURE <i>Julia Swenson-Randall</i>	

063863 AUG 26 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

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003003 003003

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 7 0 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		7 12 19 87		2b. HOUR	
Clarence						Gaines									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		24. HOUR	
M		B		9 1 14		72 YRS.		MONTHS DAYS		HOURS MIN.		7 12 19 87		8:55A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
				U.S.A.								Baltimore City, MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				St. Paul St. & Fayette St.											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MD.								BALTIMORE				21215 former 2914 Oakford Ave. address			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				17. INFORMANT				ADDRESS			
FIRST MIDDLE LAST				FIRST MIDDLE LAST				Officer Coward - B.P.D.				516 Unit			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
				217-12-0930				Officer Coward - B.P.D.				516 Unit			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7 12 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject strangled							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 7/12/87			
EXAMINER'S NAME (TYPE OR PRINT)				Charles P. Kokes, M.D.								ADDRESS 111 Penn St. Balto.MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Removal				8-12-87											
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
State Anatomy Board				AUG 24 1987 John Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE CALL THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AT 410-861-1234 FOR ASSISTANCE.

PAGE 1

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL

PAGE 2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE CALL THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AT 410-861-1234 FOR ASSISTANCE.

PAGE 3

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL

PAGE 4

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE CALL THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AT 410-861-1234 FOR ASSISTANCE.

PAGE 5

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL

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(VR A15 ME (5))

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62972 AUG 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 22704

1 DECEASED NAME (TYPE OR PRINT) FREDERICK JACK GAINES				2a DATE OF DEATH MONTH DAY YEAR 8 / 9 / 87				2b HOUR 1145 AM					
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 6 3 21		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7 UNDER 1 YEAR MONTHS DAYS 66		7c HOURS MIN. 1145			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OKLAHOMA				7b CITIZEN OF WHAT COUNTRY? USA				9 BALTIMORE CITY OR COUNTY OF DEATH Balt. City. MD.					
10 CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARY. Institute for Emery. med. Serv.				12a USUAL OCCUPATION COMMODITY INDUSTRY				12b KIND OF BUSINESS OR INDUSTRY SPECIALIST - COMMERCE DEPT.	
13a. STATE MD				13b. COUNTY ST. MARY'S		13c. CITY OR TOWN Leonardtown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 173 Glen Circle Dr. 20650			
14. FATHER'S NAME FIRST MIDDLE LAST OTIS L. GAINES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA J. HACKNEY									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 458-01-2816		17 INFORMANT RUTH C. GAINES, 173 GLENN CIRCLE, LEONARDTOWN, MARYLAND							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										48°			
DUE TO, OR AS A CONSEQUENCE OF (c) cerebral aneurysm rupture.										48°			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ① multiple contusions of brain. ② Basilar skull fractures.													
19a DATE OF OPERATION none				19b CONDITION FOR WHICH OPERATION WAS PERFORMED none				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:00 AM 8 7 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fell down stairs. ? 2° to aneurysm					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) unknown				21f LOCATION STREET CITY OR TOWN COUNTY STATE unknown Leonardtown ST. MARY'S MD.					
22a. I certify that (I) (this hospital) attended the deceased from 8/8/87 19 to 8/9/87 19, that (I) (we) last saw the deceased alive on 8/8 19 07 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Eugene F. Foley				DEGREE MD				22c. DATE SIGNED 8/9/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene F. Foley				22e ADDRESS MEIMS, Balt. MD.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 8/13/87		23c NAME OF CEMETERY OR CREMATORY CHARLES MEMORIAL GARD				23d LOCATION CITY OR TOWN COUNTY STATE LEONARDTOWN, ST. MARY'S MD.			
24 FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR.,				ADDRESS LEONARDTOWN, MD.				25 DATE OF RECORDING AUG 17 1987					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

8581 AUG 18 01

RECEIVED

AUG 17 1901

064498 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22705
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM CICCERO GALLAHAIR <i>William Ciccero Gallahair</i>			2a. DATE OF DEATH MONTH DAY YEAR 08 28 87			2b. HOUR 11:13 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 15 29		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore, City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION Supervisor Water Treatment		12b. KIND OF BUSINESS OR INDUSTRY Public Utility	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6 Maple Ave 21040	
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Gallahair					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Elizabeth Adams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 417-32-1085		17. INFORMANT ADDRESS Barbara H. Gallahair 6 Maple Ave. Edgewood, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) idiocentric arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) vasculitis DUE TO, OR AS A CONSEQUENCE OF (c) sepsis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 2 months 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/25/87 , 19____, to 8/28/87 , 19____, that (I) (we) last saw the deceased alive on 8/28/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Theodore MacKinnon				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore MacKinnon				22e. ADDRESS 4940 Eastern Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Sept. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Maryland			
24. FUNERAL DIRECTOR NAME Howard K. McComas III				ADDRESS Abingdon, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 1 - 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

004488 SEP-50

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064108 AUG 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8722706
REG. NO. 22

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
PATSY GARRETT COLLETON GANTT		8/26/87							
3. SEX FEMALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 6/28/1907		6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Car Mc Clellanville		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City		MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1020 Brantley Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1020 Brantley Ave. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Colleton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Branton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Charlotte Thompson 2611 Cylburn Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple myeloma.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.		22b. SIGNATURE <u>S. Needleman</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-26-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. NEEDLEMAN MD		22e. ADDRESS Univ. of Md Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HEIGHTS		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE John Gordon			

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Analysis of the data

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064392 SEP-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22707

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathleen PEAKL Gary			2a. DATE OF DEATH MONTH DAY YEAR 8 / 29 / 87		2b. HOUR 11 4 M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 12 25		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAMAICA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.			13b. COUNTY	13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Gooden			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-60-8075		17. INFORMANT ADDRESS Joseph GARY 2613 E. HOFFMAN ST #21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ? OF BLOOD DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE FRED LEVY		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRED LEVY		22e. ADDRESS ✓ FSK Hospital Eastern Ave. Balt., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-5/87	23c. NAME OF CEMETERY OR CREMATORY ARBITUS MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CITY MD.
24. FUNERAL DIRECTOR Bett's Funeral Home 129 N. Caroline St		25a. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

2 2 7 0 8

1. DECEASED NAME (TYPE OR PRINT) PETER GAYLES			2a. DATE OF DEATH MONTH DAY YEAR 8 15 87		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 7 21 14		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF BUSINESS OR PART OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY WEST. ELEC.
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3020 W. MOSHER STREET 21216	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES GAYLES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 118-09-3873A		17. INFORMANT ADDRESS LILLIAN GAYLES 3020 W. MOSHER STREET	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metabolic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Renal failure, Metabolic Imbalance</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 14</u> , 19 <u>87</u> , to <u>August 15</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>August 15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Wallace R. Johnson M.D.</u>		DEGREE		22c. DATE SIGNED <u>August 15, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wallace R. Johnson M.D.</u>		22e. ADDRESS <u>Union Memorial Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/22/87	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.		ADDRESS 4300 WABASH AVE.		25a. DATE REC'D. BY REGISTRAR AUG 19 1987	25b. REGISTRAR'S SIGNATURE <u>John R. Anderson</u>

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WINDMILL BRAND

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22709

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Nellie</i>	MIDDLE	LAST <i>Gee</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>8 8 87</i>		2b. HOUR <i>6²⁰ A.M.</i>		
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 30 00</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (COUNTY) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deaton Hospital & Medical Center</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland</i>		13b. COUNTY <i>Cummys Mills</i>		13c. CITY OR TOWN <i>Cummys Mills</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>22 E. Richmar Road 21117</i>	
14. DECEASED'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Westley Bellfield</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lelia Drummonds</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>239-38-0515</i>		17. INFORMANT ADDRESS <i>Mary Mills 22 E. Richmar Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of vomitus</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>dementia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>pancreatic cancer</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/28/87</i> , 19 <i>87</i> , to <i>Aug 8</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>8/8/87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>L. Parkhurst</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>8/8/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. PARKHURST</i>		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/13/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Littleton, N.C.</i>			
24. FUNERAL DIRECTOR NAME <i>Wm C. March F/H West</i>		ADDRESS <i>4300 Wabash Ave.</i>		25. DATE RECEIVED BY REGISTRAR <i>AUG 11 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22710

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM D. GEE			2a. DATE OF DEATH MONTH DAY YEAR 8 / 30 / 87		2b. HOUR 10 ⁵⁸ AM
3. SEX M.	4. RACE B. 2	5. DATE OF BIRTH MONTH DAY YEAR 12 23 47		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY. MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY ---0---
13a. STATE MD.			13b. CITY OR TOWN None	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 3021 Roseland Ave. 21215
14. FATHER'S NAME FIRST MIDDLE LAST None			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Otellia Burnice Gee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 224667604		17. INFORMANT ADDRESS 5601 Loch 21239, Baltimore MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumocystic Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AIDS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is <u>Renal Failure (end stage).</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> 19 <u>87</u> , to <u>8/30</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Daalouf MD				22c. DATE SIGNED 8/30/87 11 ³⁰ am	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASSAAD DAALOUF				22e. ADDRESS 5601 Loch Farm Rk Rd Balt MD 21239	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/5/87		23c. NAME OF CEMETERY OR CREMATORY Dinwiddly Mem Cemetery	
23d. LOCATION (CITY OR TOWN) Va.		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Law, Funeral Home 4611 Park Heights Ave. AUG 31 1987					
25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Benson-Rudolph					

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062997 AUG 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22711
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William L. Geisler			2a. DATE OF DEATH MONTH DAY YEAR Aug. 14, 1987		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1751 Belt St. Balto. Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Insulator		12b. KIND OF BUSINESS OR INDUSTRY Locke Insulat
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Geisler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-01-0278		17. INFORMANT ADDRESS Md. 21230 M. Lorraine Giffi, 1528 Boyle St. Balto.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Obstructive Pulmonary Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1980, to Aug 13, 1987, that (I) (we) lost saw the deceased alive on 8-13-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. Sollod</u>		DEGREE M.D.		22c. DATE SIGNED 8-14-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aaron C. Sollod, M.D.		22e. ADDRESS 707 E. Fort Ave. Balto. Md. 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/18/1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. Balto. A.A. Co. Maryland	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. 21230		24. FUNERAL DIRECTOR NAME Balto. Md. 21230 McCully Funeral Home, 150 E. Fort Ave.			
25a. DATE OF REGISTRATION AUG 17 1987		25b. REGISTRAR'S SIGNATURE J. R. Riddle			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

062307 AUG 18 81

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D.C. 20315

177

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D.C. 20315

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D.C. 20315



UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D.C. 20315

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D.C. 20315

063090 AUG 19 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 7 1 2

1. STATE REGISTRAR FOR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW T. GEORGE		MONTH DAY YEAR 8 15 87		9 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-9-1905	6. AGE (IN YEARS LAST BIRTHDAY) 81	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Self Employed Decorator		
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4208 Stanwood Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew M. George		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernadine Noakes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-22-9951	17. INFORMANT ADDRESS Catherine George, Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Severe myocardial necrosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute inferior wall myocardial infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Refractory tachycardia</u>					
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NA		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2) NA	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> , 19 <u>87</u> , to <u>8/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N.J. Kohleman</u>		DEGREE MD		22c. DATE SIGNED 8/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.J. KOHLEMAN		22e. ADDRESS 201 E. UNIVERSITY PARKWAY UNION MEMORIAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-18-87	23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.		25a. DATE REC'D BY REGISTRAR AUG 18 1987			

063030 AUG 1981

20% COTTON FIBER

WILSON
JUL 15 1981



AUG 18 1981

062875 AUG 17 1987

FOR
REGISTRATIONSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 2 27 1 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William German			2a. DATE OF DEATH MONTH 8 DAY 8 YEAR 87			2b. HOUR 1:40 AM					
3. SEX M		4. RACE B 2		5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 35		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital + Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Technician			12b. KIND OF BUSINESS OR INDUSTRY Medicine		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2304 Madison Avenue 21217			
14. FATHER'S NAME FIRST Larry MIDDLE B LAST Hill			15. MOTHER'S MAIDEN NAME FIRST General MIDDLE Cannon LAST Cannon								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1955-58		16c. SOCIAL SECURITY NO. 21330-6209		17. INFORMANT ADDRESS Alice M. Williams 2023 N. Bentslou St. 21216					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) non small cell lung carcinoma, metastases to spine DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (this hospital) attended the deceased from 7/24/87 19 87 to Aug 8th 19 87 , that (I) (we) last saw the deceased alive on Aug 7th 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Parkhurst MD						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA A. PARKHURST						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-12-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet.			23d. LOCATION (CITY OR TOWN) Owings Mills Md. COUNTY _____ STATE _____			
24. FUNERAL DIRECTOR NAME Wm. C. Brown ADDRESS 1206-08 W. North Ave. 21217						25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE L. E. Knidner-Randall			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits (except carbon papers, pages 1 and 2) should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

062672 AUG 17 87

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "B", "C", "D", "E", "F", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P", "Q", "R", "S", "T", "U", "V", "W", "X", "Y", "Z" are visible.]

062672 AUG 17 87

062814

AUG 14 87
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22714
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Leary NMI Gibson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8-7-87</i>		2b. HOUR <i>2:54 AM</i>	
3. SEX <i>MALE</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11-19-38</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>48</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA-SCAR.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Univ. of Md. Medical Systems</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>
13a. STATE <i>MD.</i>			13b. COUNTY <i>BALTO. CITY</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Eddie NMI Gibson</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MATTIE Richburg</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>216-34-7686</i>		17. INFORMANT <i>MATTIE RICHBURG</i> ADDRESS <i>201 N. BROADWAY BALT. MD 21205</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiac arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>mitral valve regurgitation</i>						<i>unknown</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>mitral valve endocarditis</i>						<i>unknown</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>drug abuse</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>August 7, 1987</i> to <i>August 7, 1987</i> , that (I) (we) last saw the deceased alive on <i>August 7, 1987</i> , and that in (my) (our) opinion death occurred on <i>August 7, 1987</i> and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Wm E. Gains, M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>8/7/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm E. Gains, M.D.</i>				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>Aug 12, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. ZION</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MD</i>
24. FUNERAL DIRECTOR NAME <i>GARY L. ROLLINS FUN. SER. FREDERICK, MD 21701</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 13 1987</i>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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085814 AUG 14 83

065100 SEP 10 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22715
REC. NO.

1- STATE REGISTRAR		FOR					
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH	2b. HOUR	
Rose				Gillard	DATE ESTIMATED MONTH DAY YEAR 8 27 87	2b. HOUR M M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Female	Black	2-17-32	55 YRS.			9 1 19 87	3:26 P M
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		X U.S.				Baltimore City MD	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		419 Edsdale Road					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Maryland				Baltimore		419 Edsdale Rd Apt C	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Walter Lee Matthews		Violet Mae Imes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		218-26-3921		Floritta Washington 3214 HowardPk A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Alcoholism</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? HEAD & ABD. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Mario F. Golle, Jr. Md		Assistant MEDICAL EXAMINER		9/2/87			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTO. MD			
Mario F. Golle, Jr., M.D.		111 Penn St.		Balto. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9-5-87		Crownsville Veteran		Crownsville MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Irvin Carroll		1712-14 W. North Av.		SEP 9 1987		Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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064805 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22716
REG. NO.1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) ROBERT GILLESPIE		2a. DATE OF DEATH MONTH 8 DAY 30 YEAR 87		2b. HOUR 11-15 M	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 1 DAY 31 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST CHARLES MIDDLE LAST GILLESPIE		15. MOTHER'S MAIDEN NAME FIRST ROSA MIDDLE LAST SALLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 229-14-0994A		17. INFORMANT ADDRESS PAULINE LOYAL 2549 KIRK AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (c) VALVULAR HEART DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-14-19-87 to 8-30-19-87 that (I) (we) last saw the deceased alive on 8-30-19-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Anil Raker MD				22c. DATE SIGNED 8-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL RAIKER MD				22e. ADDRESS 2 MC.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/4/87		23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE 1 ANSDOWNE MD					
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.				25a. DATE REC'D. BY REGISTRAR SEP 3 1987	
ADDRESS 1101 E. NORTH AVENUE				25b. REGISTRAR'S SIGNATURE Julia Anderson-Rudner	

064802 SEP-4 03

062540 AUG 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22717

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Edward GINNEMAN			7a. DATE OF DEATH MONTH DAY YEAR 8-3-87 9:50 P.M.		
3. SEX Male	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 4 12 29	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7b. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dis. Dockman		
13a. STATE Maryland	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WALTER Ellsworth GINNEMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET Charlotte RICHARDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-22-6154		17. INFORMANT ADDRESS Mrs. Esta M. Ginneman Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emboli or Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Severe PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUG. 3 , 19 87 , to AUGUST 3 , 19 87 , that (I) (we) last saw the deceased alive on AUG-3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Fein Gold		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT FEINGOLD		22e. ADDRESS 3001 S-HANOVER ST. BALTO, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/6/87		23c. NAME OF CEMETERY OR CREMATORY Security Process	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Md.		25a. DATE REC'D. BY REGISTRAR AUG 11 1987			
24. FUNERAL DIRECTOR NAME McCully Funeral Homes		24b. ADDRESS 237 E. Patapsco Ave., Balto., Md. 21225		25b. REGISTRAR'S SIGNATURE Gordon R. Riddle	

MEDICAL CERTIFICATION

1
2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return both papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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005240

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22718
REG. NO.

FOR Item 1,5 Film G630
1- STATE 8-20-87 per F.H dw
REGISTRAR

DECEASED NAME Beatrice		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH 8/ 18/19 87		2b. HOUR 7:12 a m	
3 SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH 1920 3 9 19		6. AGE (IN YEARS) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 8/ 18/19 87		2d. HOUR 7:12 a m	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,				MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2222 E. Oliver St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2222 E. OLIVER STREET 21213			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES A. JEFFRIES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. COSBY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-20-2310		17. INFORMANT VANESSA ROSCOE		ADDRESS 2222 E. OLIVER STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with Diabetes Mellitus</u> XXXXXXXXXXXXXXXXXXXX Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 8/19/87					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/21/87		23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN MD					
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE		25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

23418 AUG 51 81



23418 AUG 51 81

064698 SEP-3 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22719

1. DECEASED NAME (TYPE OR PRINT) ALICE GLOVER			2a. DATE OF DEATH MONTH DAY YEAR 8-30-87			2b. HOUR M 1:20 P.			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 6 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1218 N. BENTALOU STREET 21216	
14. FATHER'S NAME FIRST MIDDLE LAST N/A				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-14-0633A		17. INFORMANT ADDRESS THEODORE GLOVER 1218 N. BENTALOU STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE, COPD									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-13-1987 to 8-30-1987 , that (I) (we) last saw the deceased alive on 8-30-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N RAIKER				22e. ADDRESS LMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/3/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT'L CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD			
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 02 1987 <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DELIVERED

10/10/50

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063187 AUG 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 7 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas M Glover			2a. DATE OF DEATH MONTH DAY YEAR 8-11-87		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12-12-12		6. AGE (IN YEARS LAST BIRTHDAY) 74	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT KNOWN, GIVE STREET ADDRESS) 629 FRANKLIN TOWN RD.		12a. USUAL OCCUPATION (TYPE AND MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Franklin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALVA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 239-20-7057		17. INFORMANT ADDRESS CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ventricular arrhythmias DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease					4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Coronary vascular disease					5 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frederick Sutton MD				22c. DATE SIGNED 8-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick Sutton MD				22e. ADDRESS 201 E University Pkwy Bldg Md 2121A	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-17-87	23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MARYLAND
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS			25a. DATE REC'D. BY REGISTRAR AUG 18 1987		
ADDRESS 1721 N. MONROE ST.			25b. REGISTRAR'S SIGNATURE John Davidson-Rudner		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other medical examiner must be notified to one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 22721

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LOUIS

E

GODLEY JR.

2a. DATE OF DEATH MONTH DAY YEAR

AUGUST 2, 1987

2b. HOUR P

4:10 M

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH

DAY

YEAR

8

3

54

6. AGE (IN YEARS LAST BIRTHDAY)

32

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

N.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

939 DURHAM STREET 21213

14. FATHER'S NAME

LOUIS

MIDDLE

E.

LAST

GODLEY SR.

15. MOTHER'S MAIDEN NAME

PRISCILLA

MIDDLE

LAST

YARBOROUGH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

212-60-4879

17. INFORMANT

ADDRESS

PRISCILLA YARBOROUGH 1125 BRENTWOOD AVE.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 minutes

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Gram-negative sepsis

12 hours

DUE TO, OR AS A CONSEQUENCE OF

(c)

A. I. D. S.

months.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from July 27, 1987, to Aug 2, 1987, that (I) (we) last saw the deceased alive on August 2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/2/87

23a. PHYSICIAN'S NAME (TYPE OR PRINT)

NANCY D WILSON

23b. ADDRESS

600 N. Wolfe St. Baltimore MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/8/87

23c. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEMETERY

23d. LOCATION

BALTIMORE,

COUNTY

MD

STATE

24. FUNERAL DIRECTOR

NAME

WM. C. MARCH F/H, INC. 1101 E. NORTH AVE.

25a. DATE REC'D. BY REGISTRAR

AUG 7 1987

25b. REGISTRAR'S SIGNATURE

Julia Swinton-Baker

085350 AUG 11 85

RECEIVED
11 AUG 1985
10 10 10

11 AUG 1985

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22722

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGARET		FIRST GOEB		LAST		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 17, 1987				2b. HOUR A 7:30	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS 82				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltc		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 416 Clc Ham Street 21224			
14. FATHER'S NAME FIRST MIDDLE LAST Kane				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Huggins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-24-9245		17. INFORMANT ADDRESS Anna Schatzschneider 4020 Abingir Dr. 21009							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE-CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) ATRIAL FIBRILLATION											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JULY 6, 1987 , to AUGUST 17, 1987 , that (I) (we) last saw the deceased alive on August 17, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.											
22b. SIGNATURE <i>W. J. J. J.</i>										22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER IMPAGLIATELLI						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR Connolly Funeral Home						25a. DATE REC'D. BY REGISTRAR AUG 21 1987		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages one and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 7 2 5

REG. NƠ

1. DECEASED NAME (TYPE OR PRINT)		FIRST ELAINE		MIDDLE		LAST GOLDBERG		2a. DATE OF DEATH MONTH DAY YEAR August 13, 1987		2b. HOUR 9:40 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 3, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHN'S HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 CHERRY VALLEY RD. 21136			
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS GOLDBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE GREENBERG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-28-3659		17. INFORMANT SIDNEY GOLDBERG 108 CHERRY VALLEY RD. REISTERSTOWN, MD 21136							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrinoma</u> Approximate interval between onset and death: <u>5 min</u> <u>1 week</u> <u>6 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>August 6</u> , 19 <u>87</u> , to <u>August 13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) new the body after death.											
22b. SIGNATURE <u>David Gerard, MD</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>August 13, 1987</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David Gerard</u>						22e. ADDRESS <u>600 N. Wolfe St. Baltimore, MD 21205</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Bender-Rudner</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the decedent be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP.

0-63358-107

Aug 30 1891

64897 SEP-88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22724

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilbert Goldberg			2a. DATE OF DEATH MONTH DAY YEAR 08 28 87		2b. HOUR 6:37 P.M.								
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 17 19		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 68		IF UNDER 24 HRS HOURS MIN 68			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY RETAIL					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND						13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6820 OLD PIMLICO RD. #21209	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS GOLDBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RAY ELVIDGE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 098-10-1799		17. INFORMANT MRS. ESTHER GOLDBERG 6820 OLD PIMLICO RD. #21209									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ca BLADDER													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 19 87 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/29/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORTS KATZNER				22e. ADDRESS 4000 OLD COURT RD, BALTO 21208									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-30-87		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CHIZUK AMONO		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD							
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR SEP 4 1987						25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 27 25

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMANUEL GOLDSTEIN		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 6, 1987		2b. HOUR 8:30 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT: 22, 1896	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 90 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIEDLER NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DELIVERYMAN		12b. KIND OF BUSINESS OR INDUSTRY TELEGRAMS			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MIDDLE COUNTY MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS GOLDSTEIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA GROSSMAN		13d. STREET ADDRESS & ZIP CODE 125 PINE ST. (21201)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-52-0216		17. INFORMANT ADDRESS MRS. RITA GERBER 3237 ROLLING RD. (21207)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Lymphatic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Heart Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Aug 10, 1980</u> to <u>Aug 6, 1987</u> that (I) <u>have</u> lost saw the deceased alive on <u>Aug 6, 1987</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.					
22b. SIGNATURE <u>Manuel Levin</u> M.D.		22c. DATE SIGNED 8/7/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN		22e. ADDRESS 6101 PARK HEIGHTS AVE, (21215)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/7/87		23c. NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL	
23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE, BALTO., MD.		23e. DATE OF BURIAL, CREMATION, REMOVAL AUG 12 1987 <u>Julius Levinson-Rosedale</u>			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)					

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063084 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22720

1. DECEASED NAME (TYPE OR PRINT) JOHN HOLT GONTRUM			2a. DATE OF DEATH MONTH DAY YEAR 8-16-87			2b. HOUR 9:50 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 20, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Emp.		12b. KIND OF BUSINESS OR INDUSTRY Farmer	

13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12. STREET ADDRESS & ZIP CODE 6940 Mt. Vista Rd. 21087	
14. FATHER'S NAME FIRST MIDDLE LAST John B. Gontrum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary von Wyszęcki					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 220-32-3162		17. INFORMANT ADDRESS Mrs. Marilyn B. Gontrum, same as #13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 33 days	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fever of Unknown Origin</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	

22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>87</u> , to <u>8/16</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Breiner MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BREINER</u>		22c. DATE SIGNED <u>8/16/87</u>	
22e. ADDRESS <u>201 E. University Parkway Union Memorial Hosp.</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-19-87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION Pikesville, Maryland STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR AUG 18 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

003084 AUG 19 81

20% COTTON FIBER

AUG 18 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTER

1. DECEASED NAME (TYPE OR PRINT) Rusell D. Goode			2a. DATE OF DEATH MONTH DAY YEAR 8 5 1987			2b. HOUR M				
3 SEX male		4 RACE black		5. DATE OF BIRTH MONTH DAY YEAR 12 25 1901		6 AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3006 Presstman Street				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Md			13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3006 Presstman Street 21216	
14 FATHER'S NAME FIRST MIDDLE LAST Ned Goode			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Riddle							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 212-07-9243		17 INFORMANT Carolyn V. Johnson		ADDRESS 3006 Presstman Street				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Adenocarcinoma Prostate</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3yr 4mos</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>spinal cord compression @ T₁₂</i> <i>5mos</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>bone metastasis</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Congestive Heart Failure, Diabetes Mellitus, Aortic Insuff</i>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (this hospital) attended the deceased from above <i>6-29-87</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated										
22b SIGNATURE <i>Glen E. Johnson</i> DEGREE <i>MD</i>				22c DATE SIGNED 8/06/87						
22d PHYSICIAN'S NAME (TYPE OR PRINT) GLEN E. JOHNSON, M.D.				22e ADDRESS 1001 PINE HGTS. AVE. BALCO. MD. 21229						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/11/87		23c NAME OF CEMETERY OR CREMATORY Arbutus Mem Park		23d LOCATION CITY OR TOWN COUNTY STATE Arbutus MD				
24 FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue				25a DATE REC'D BY REGISTRAR AUG 11 1987		25b REGISTRAR'S SIGNATURE <i>Julia...</i>				

1065010 AUG 13 81

62095 AUG -8

1 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7
REG. NO.

2 27 28

1 DECEASED NAME (TYPE OR PRINT) LENA GOODMAN			2a DATE OF DEATH MONTH DAY YEAR 8 28 87			2b HOUR 0540 M				
3 SEX FEMALE		4 RACE Cauc		5 DATE OF BIRTH MONTH DAY YEAR 3 10 06		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY AT HOME				
13a STATE Maryland			13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME DAVID GOLDMAN			15 MOTHER'S MAIDEN NAME FANNIE FRIEDMAN			16a STREET ADDRESS / ZIP CODE 4008 Emmart Ave, 21215				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO UNKNOWN			16b SOCIAL SECURITY NO. 212-03-1873D 001-21-4577		17 INFORMANT ARNOLD L. GOODMAN 4008 EMMART AVE. BALTO., MD 21215					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Roxanne S. Donovan MD						22c DATE SIGNED 8/2/87		22d PHYSICIAN'S NAME (TYPE OR PRINT) Roxanne S. Donovan		
22e ADDRESS Sinai Hospital										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE AUG. 4, 1987		23c NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH		23d LOCATION BALTIMORE		COUNTY MARYLAND	
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a DATE REC'D. BY REGISTRAR AUG 5 1987		25b REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and a medical examination must be conducted.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22729

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MORRIS				GORDON	AUGUST 17, 1987				7:20P M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE	CAUCASIAN	OCTOBER 30, 1911			75	MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.				BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	INNS OF EVERGREEN NURSING HOME			CHAUFFEUR		TAXI CABS			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MARYLAND			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4010 ERDMAN AVE. (21213)		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
ABRAHAM		LENA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		218-03-7477		JENNIE GORDON 4010 ERDMAN AVE. (21213)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Acute Cardiac - Respiratory Failure</i>									-
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Renal Failure</i>									days
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetic Nephropathy</i>									years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
<i>Renal Transplantation, Renal Urinary Tract Infection, Diabetic mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (1) (the decedent) attended the deceased from <i>8/17/87</i> to <i>8/17/87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Albert B. Bradley</i>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/18/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT B. BRADLEY, M.D.				22e. ADDRESS 4900 BELAIR RD. BALTO., M D					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE
BURIAL		8/19/87		MIKRO KODESH CEMETERY		BALTIMORE			MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25. DATE REC'D. BY REGISTRAR AUG 20 1987			
						26. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

063338 AUG 31 87

AUG 30 1887

062465 AUG

FOR
22730
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
FIRST MIDDLE LAST ADAM GORRAY			MONTH DAY YEAR 08/09/87			12:47 AM					
3. SEX male		4. RACE white		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		82 YRS					
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore			9b. CITIZEN OF WHAT COUNTRY? USA			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED CTR.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1808 Snyder Ave. 21222	
14. FATHER'S NAME Gottlieb			15. MOTHER'S MAIDEN NAME Justina			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 213-07-4916		
17. INFORMANT Emma Gorray			18. ADDRESS 1808 Snyder Ave, 21222			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 P.M. 8 4 1987		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Pt. fell off ladder			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1808 Snyder Ave Dundalk MD		
22a. I certify that (I) (this hospital) attended the deceased from August 4, 1987, to August 9, 1987, that (I) (we) last saw the deceased alive on August 9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Caroline C. Philpott MD			22c. DATE SIGNED 8/9/87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Caroline C. Philpott		
22e. ADDRESS Dept. of Medicine Johns Hopkins Hospital			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/12/87			23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran Cemetery		
23d. LOCATION CITY OR TOWN Baltimore Maryland			24. FUNERAL DIRECTOR Connelly Funeral Home of Dundalk			25a. DATE REC'D. BY REGISTRAR AUG 11 1987			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not while at work" or "other traumatic event," the medical examiner must be notified of case.

005462 AUG 15 83

RECEIVED

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10/1/83

10/1/83

10/1/83

10/1/83

10/1/83

062985 AUG 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 27 3 1

1 DECEASED NAME (TYPE OR PRINT) Genevieve C. Gossman			2a. DATE OF DEATH MONTH DAY YEAR Aug. 15, 1987		2b. HOUR M 1
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD	
10 CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1016 Haverhill Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife	
13a. STATE Md.			13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Shepherd Farren			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Urbanski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217 14 0468A		17 INFORMANT ADDRESS 1016 Haverhill Rd. Balto. Md. 21229 Mrs. Joan M. Murphy	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION 5/9/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma sigmoid colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) mb	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) mb		21f. LOCATION STREET CITY OR TOWN COUNTY STATE mb	
22a. I certify that (I) (this hospital) attended the deceased from May 26, 1987 to Aug 15, 1987 , that (I) (we) lost saw the deceased alive on July 31, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles R. Graham, Jr.		DEGREE MD		22c. DATE SIGNED 8-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Graham, Jr. M.D.		22e. ADDRESS 299 Frederick Road Balto. MD 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 18, 1987	23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Howard Md.
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike 21229				25. DATE REC'D BY REGISTRAR AUG 17 1987	
				26. REGISTRAR'S SIGNATURE John Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Continued from page 1

1. The first of the three main components of the system is the input device, which is used to enter data into the system.

2. The second component is the processing unit, which performs the operations specified by the program.

3. The third component is the output device, which is used to present the results of the processing to the user.

4. The fourth component is the storage device, which is used to store data and programs.

5. The fifth component is the communication device, which is used to connect the system to other systems.

6. The sixth component is the control device, which is used to manage the system.

7. The seventh component is the monitoring device, which is used to monitor the system.

8. The eighth component is the maintenance device, which is used to maintain the system.

9. The ninth component is the documentation device, which is used to document the system.

10. The tenth component is the evaluation device, which is used to evaluate the system.

064307 SEP 1 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 7 3 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
DARRELL WAYNE GOUGH						8-23-87			8-23-87			10:25P					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		Black		11 26 56		30		MONTHS DAYS		HOURS MIN		8-23-87		10:25P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.				USA								Baltimore City MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				716 N. Charles Street Apt. 703													
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1910 Etting Street 21217							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Raymond J. Gough						Ardeen Britton											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
No												Raymond J. Gough 1910 Etting Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
				10:15P 8-23-87				subject shot during an altercation									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				livingroom				716 N. Charles Street Apt. 703 Balto., Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Margarita A. Korell, M.D.				M.D. Assistant				8-23-87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				9/1/87				Garden of Eternal Hope				Deer Park Balto. Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Chatman-narris				1701 McCulloh Street				AUG 31 1987									

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3, RETAINING PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Aug 31 1967

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 22733

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles W. GOULDIN, SR.			2a. DATE OF DEATH MONTH DAY YEAR 8 21 87		2b. HOUR 750 8:15 PM	
3. SEX MALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 6 16 17		6. AGE (IN YEARS LAST BIRTHDAY) 70	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH. Baltimore MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Misc. Duties		12b. KIND OF BUSINESS OR INDUSTRY Rubber Company	
13a. STATE Md.	13b. COUNTY ---	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 322 S. Wood Year St. 21223		
14. FATHER'S NAME FIRST MIDDLE LAST George Gouldin	15. MOTHER'S MAIDEN NAME MIDDLE LAST Myrtle Tweedell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II			
16b. SOCIAL SECURITY NO. 218-03-2479		17. INFORMANT James Gouldin, 8244 Church Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Philip Konits		DEGREE		22c. DATE SIGNED 8/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Konits		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE Donna R. Radabaugh

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 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and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 27 34

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE A GRABER			2a. DATE OF DEATH MONTH DAY YEAR 8/14/87		2b. HOUR 9 44 AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12/20/1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 84		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUTTON HOLE MAKER		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG.		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6319 Mt. Ridge Rd. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Ferowitz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Zukauskas			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 216-07-6923			17. INFORMANT ADDRESS ANNA R. WASSELL - 1644 Northbourne Rd. Baltimore 21239							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarction of stomach, small intestine + proximal colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Mesenteric artery thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Atherosclerosis, mesenteric + celiac arteries</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from 8/13 19 87 , to 8/14 19 87 , that (I) (we) last saw the deceased alive on 8/14 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.										
22b. SIGNATURE <i>William J. Hicken</i>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WM J HICKEN				22e. ADDRESS St Agnes Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08-17-1987		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR OR NAME Le M. & Russell C. Witzke Funeral Homes P.A.				ADDRESS 1630 Edmondson Ave., Catonsville MD. 21228		DATE REC'D. BY REGISTRAR AUG 17 1987		REGISTRAR'S SIGNATURE <i>John Davidson</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22735

REG. NO.

1- REGISTRAR NAME JAMES D. GRANGER		FIRST JAMES		MIDDLE D.		LAST GRANGER		2a DATE KNOWN OF DEATH ESTIMATED 8-15-87		MONTH DAY YEAR 8-15-87		2b HOUR M 1:57a			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov 22 1929		6 AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD 8-15-87			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		MD	
10 CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer				12b KIND OF BUSINESS OR INDUSTRY Balto City			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a STATE Maryland				13b COUNTY Anne Arundel				13c CITY OR TOWN Baltimore				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e STREET ADDRESS 5331 Wasena Avenue 21225				14 FATHER'S NAME FIRST MIDDLE LAST Thomas Leo Granger				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian A. Douglas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b SOCIAL SECURITY NO. WW II 216-24-8828				17 INFORMANT Barbara Liverette				ADDRESS Stevensville Md 21666 202 Petinot Drive			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8809 IMMEDIATE CAUSE (a) Head injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I arteriosclerotic cardiovascular disease and chronic alcoholism															
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY DATE MONTH DAY YEAR 12:50a 8-15-87				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject fell down stairs							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f LOCATION 5331 Wasena Avenue				CITY OR TOWN Anne Arundel Co., Md.			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Mario F. Golle, Jr.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 8-15-87							
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.				ADDRESS 111 Penn Street											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b DATE 8/18/87				23c NAME OF CEMETERY OR CREMATORY Westview Memorial Park				23d LOCATION Catonsville Balto Md			
24 FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy Balto Md				25a DATE REC'D. BY REGISTRAR AUG 17 1987				25b REGISTRAR'S SIGNATURE Julia Benson-Rudolph			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMM - 17
(VR A15 ME (5))

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WIND

WIND

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22736
REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Geneva

Graves

2. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR
10 / 30 / 17

2a. DATE OF DEATH MONTH DAY YEAR
8/30/87 8/30/87

2b. HOUR

5:56 PM

6. AGE (IN YEARS LAST BIRTHDAY)

69 YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

N.C.

7b. CITIZEN OF WHAT COUNTRY?

USA.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FRANCIS SCOTT KEY MED CTR

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Nurse

12b. KIND OF BUSINESS OR INDUSTRY

Health

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

120 Honey Suckle CT 21222

14. FATHER'S NAME FIRST

James

MIDDLE

A.

LAST

Highsmith

15. MOTHER'S MAIDEN NAME FIRST

Maggie

MIDDLE

Farrow

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

220-22-9843

17. INFORMANT

Mrs. Shirley Graves Burks 105 Beechwood 21222

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Refractory Hypotension

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

70 min.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cerebral Anoxia

DUE TO, OR AS A CONSEQUENCE OF

(c) Cardiopulmonary Arrest

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/24/87, 19 87, to 8/30/87, 19 87, that (I) (we) last saw the deceased alive on 8/30/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

C. Philpott

DEGREE

ATTENDING PHYSICIAN ☐

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☒

22c. DATE SIGNED

8/30/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Caroline Philpott

22e. ADDRESS

Johns Hopkins Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9-3-87

23c. NAME OF CEMETERY OR CREMATORY

Md. Nat. Mem Pk.

23d. LOCATION

Laurel

COUNTY

Md.

STATE

24. FUNERAL DIRECTOR

NAME J. A. Morton & Sons

ADDRESS

1701 Laurens St.

25a. DATE REC'D. BY REGISTRAR

SEP 01 1987

25b. SIGNATURE

John A. Morton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

064201 SEP-50

DOWN

SEP 01 1950

064777 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 2 7 3 7

1. DECEASED NAME (TYPE OR PRINT) Earl			2a. DATE OF DEATH MONTH DAY YEAR 8-30-87			2b. HOUR 7:10 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 21 12		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital 2000 W. Belts				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR SUPERVISOR, A & P	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4033 St Johns Lane, Md. Ellicott City		
14. FATHER'S NAME FIRST MIDDLE LAST Francis W.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma #21043			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-03-7269			17. INFORMANT 4033 St. John's Lane-Ellicott City, Md. #21043 Mrs. Thelma F. Gray		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Pulmonary Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia (Ventricular)	
		DUE TO, OR AS A CONSEQUENCE OF (c) Tachycardia -	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/8, 19 87, to 8/30, 19 87, that (I) (we) lost saw the deceased alive on 8/29, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rolando M. Schwab				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando M. Schwab				22e. ADDRESS Bon Secour Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-87		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR J. Truman Schwab 5151 Balto. Nat'l. Pike #21229				25a. DATE REC'D. BY REGISTRAR SEP 3 1987		25b. REGISTRAR'S SIGNATURE A. J. Anderson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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064714 SEP 1-487

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 7 3 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward			2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 8-18 19 87			2b. HOUR M			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 4 DAY 21 YEAR 21	6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD 8-21 19 87	2d. HOUR 12:35 P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 30 S. Fulton Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 30 S. FULTON AVENUE			
14. FATHER'S NAME FIRST _____ MIDDLE _____ LAST _____ UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST _____ MIDDLE _____ LAST _____ UNKNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNKNOWN			
16b. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT ADDRESS Officer Sylvia Jones - Southern District						
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Chronic Alcoholism									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____				
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Charles P. Kokes</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 8-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 9-2-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____		
24. FUNERAL DIRECTOR NAME State Anatomy Board			ADDRESS Balto., Md.			25a. DATE REC'D BY REGISTRAR SEP03 1987		25b. REGISTRAR'S SIGNATURE <i>Sylvia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 14. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

064311 228-483



SEP 03 1987

063285 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22737

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GORMAN GRAY			2a. DATE OF DEATH MONTH DAY YEAR 8-13-87		2b. HOUR 1822M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR May 10 1936		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) MIEMSS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing
13a. STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Elliott	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Elliott Island/21869
14. FATHER'S NAME FIRST MIDDLE LAST Baynard Galloway Gray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Gray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Rt. ADDRESS Box 115 Florence Gray, Elliott, MD 21869	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) BRAINSTEM HERNIATION DUE TO, OR AS A CONSEQUENCE OF (c) RIGHT TEMPORAL PARIENTAL TUMOR APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) UNKNOWN					
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE R. L. POHL MD				22c. DATE SIGNED 8-13-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD L. POHL MD				22e. ADDRESS 51 GREENE ST. BALTIMORE MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-15-87		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, MD		24. FUNERAL DIRECTOR NAME ADDRESS Zeller Funeral Home, East New Market, MD			
25. DATE REC'D. BY REGISTRAR AUG 19 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove completed Page 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FM
TO
INFO
SUBJ
REF
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AUG 19 1981

2a. DATE KNOWN OF DEATH	ESTIMATED	MONTH	DAY	YEAR	2b HOUR
	<input checked="" type="checkbox"/>				
	<input type="checkbox"/>	8	8	1987	

2c	DATE	MONTH	DAY	YEAR	2d HOUR
	PRONOUNCED DEAD	8	8	1987	11:59

9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City

10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 900 Blk. Calhoun Street (on street)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
--	---	--	--------------------------------------

13a. STATE Md 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 1412 N Mount Street 21217

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Ronald	Lee	Rucker	Joyce		Green

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 219-86-0802	17. INFORMANT Joyce Green	ADDRESS 1412 N. Munt Street
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gunshot wound of head	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>	{ DUE TO, OR AS A CONSEQUENCE OF	
	(b) _____	
	{ DUE TO, OR AS A CONSEQUENCE OF	
	(c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

HIV Antibody Postive

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOURS MONTH DAY YEAR 11:51 P.M. 8 8 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot
--	---	---

21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 900 Blk. Calhoun St., Balto MD
--	---	---

22b. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

ACTUAL SIGNATURE  TITLE (SPECIFY) Deputy Chief DATE 8/9/87
MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/14/87	23c. NAME OF CEMETERY OR CREMATORY Md Veteran Cemetery	23d. LOCATION CITY OR TOWN Crownsville	COUNTY	STATE Md
--	----------------------	---	--	--------	-------------

24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue	25a. DATE REC'D. BY REGISTRAR AUG 13 1987	25b. REGISTRAR'S SIGNATURE Julia Denson Padgett
--	--	--

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A FUNERAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND NATURAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. 19TH STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

085505 VME 14 61

WATERLOO
COTTON, NO. 1



[Handwritten signature]

WATERLOO COTTON

063585 AUG 25 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22741

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Carol Lee Green						8/18/87						8-15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		1/2/43		44		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Baltimore City						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		St. Agnes Hospital		Supervisor		Universi							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland				Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3410 Kelox Road		21207	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
John Lackey				Doris Mary McLaughlin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		219-40-8187		3410 Kelox Road		Baltimore Maryland		21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA BREAST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1to													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/15, 1987, to 8/18, 1987, that (I) (we) last saw the deceased alive on 8/18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Latna R. Pillai			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/18/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PILLAI, LATNA			22e. ADDRESS St Agnes Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			8/22/87		Woodlawn Cemetery		Woodlawn Baltimore MD						
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Loring Byers Funeral Directors, Inc			AUG 21 1987			Julia Gordon-Randall							
8728 Liberty Road Randallstown Maryland 21133													

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the certificate must be notified at once.

083282 AUG 22 81

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "COUNTING" and "TOTAL" are faintly visible.]

AUG 21 1981

064060 AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 22742
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence M. Green		2a. DATE OF DEATH MONTH DAY YEAR 8 25 87		2b. HOUR 1030 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-21-1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4139 Eierman Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Ford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adda Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-05-4571		17. INFORMANT ADDRESS Md. 21087 Cecilia Gessner, 2409 Whitt Rd., Kingsville,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Inability to clear secretions DUE TO, OR AS A CONSEQUENCE OF (c) Poor nutrition, decreased mental abilities, poor cardiac function					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 IDDM, Nutrition, UTI, CRF, past MI					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/17</u> , 19 <u>87</u> , to <u>8/25</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased <u>live on</u> <u>8/25</u> , 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> (did) not view the body after death.					
22b. SIGNATURE Joseph Zibell MD		DEGREE MD		22c. DATE SIGNED 8/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeff Zibell		22e. ADDRESS Union Memorial Hosp- Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-87		23c. NAME OF CEMETERY OR CREMATORY Louden Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. DATE REC'D. BY REGISTRAR AUG 26 1987	
				25b. REGISTRAR'S SIGNATURE Julia Dickinson-Rudner	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 (this page) should be filed with the death certificate in the Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

004000 000430

43817 NOTION 202

MAILED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR by Med. Ex., / Gbj.,
1- STATE REGISTRAR

065632 SEP 15 87

1. NAME FIRST MIDDLE LAST JERRY GREEN		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 6 19 87		2b. HOUR M 10:32
3. SEX MALE	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 16 19 67	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
8. BIRTHPLACE (STATE OR COUNTRY) South Carolina		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED WIDOWED NEVER MARRIED DIVORCED
11. CITY OR TOWN OF DEATH Baltimore		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		15. USUAL OCCUPATION (TYPE OF WORK) FORMERLY OF WORKING LIFE RETIRED		16. KIND OF BUSINESS OR INDUSTRY 21213
17. 13b. COUNTY BALTIMORE		18. 13c. CITY OR TOWN BALTIMORE		19. 13d. STREET ADDRESS 2600 E. HOFFMAN STREET.
20. 14. FATHER'S NAME FIRST MIDDLE LAST TONEP GREEN		21. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Golden		22. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
23. 16b. SOCIAL SECURITY NO. 247-20-1823		24. 17. INFORMANT ADDRESS CHART		25. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism complicating subdural hematoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)
26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
27. 19a. DATE OF OPERATION		28. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		29. 20. AUTOPSY? YES X NO
30. 21a. EXTERNAL CAUSE WAS UNDERLYING OR Primary CONTRIBUTING CAUSE OF DEATH		31. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. ? 6 11 19 87		32. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject apparently fell.
33. 21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK		34. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ?		35. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE ? ? ? ?
36. 22. I certify that I took charge of the remains described above, held on Autopsy X Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner				
37. ACTUAL SIGNATURE Ann M. Dixon, M.D.		38. TITLE (SPECIFY) Deputy Chief		39. DATE SIGNED 7-7-87
40. EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		41. ADDRESS 111 Penn St., Balto., MD 21201		42. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
43. 23b. DATE 7/11/87		44. 23c. NAME OF CEMETERY OR CREMATORY ARBUTHNOT MEM. PK.		45. 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
46. 24. FUNERAL DIRECTOR NAME E. L. Phillips		47. ADDRESS 1721-27 N. MONROE ST.		48. 25a. DATE REC'D. BY REGISTRAR SEP 14 1987
49. 25b. REGISTRAR'S SIGNATURE E. L. Phillips		50. 25c. REGISTRAR'S SIGNATURE E. L. Phillips		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A PERMIT TO TRANSIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22744

1. DECEASED NAME (TYPE OR PRINT) KELLY NICOLE GREEN			2a. DATE OF DEATH MONTH DAY YEAR 8-7-87			2b. HOUR 12:13 PM				
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 23 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 1 15		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD MEDICAL SYSTEM				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY ---		13c. CITY OR TOWN BALT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2712 FAIT AVE / 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Thomas Green Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kimberly LORRY Hamilton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS Charles T. Green Jr. 2712 Fait Ave. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC CATHETERIZATION DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE PULMONARY VALVE STENOSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Hours 6 Weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:										
19a. DATE OF OPERATION 8/7/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PULMONARY VALVE STENOSIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/6, 19 87, to 8/7, 19 87, that (I) (do) saw the deceased alive on 8/7, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Richard Ringel, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/7/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD RINGEL, MD						22e. ADDRESS 34 PENNY LANE BALT, MD 21209				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland			
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. - 705 S. Ann Street						25a. DATE RECEIVED BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE John D. ...		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers from 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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062329 AUG 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 22745

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) EDWARD GREENE		2a DATE OF DEATH MONTH DAY YEAR 8 4 87		2b HOUR 3:40p.m.
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 10 17		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHN HOPKINS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED	12b KIND OF BUSINESS OR INDUSTRY KOPPERS LABORER
13a. STATE MD 13b COUNTY BALTO. 13c. CITY OR TOWN BALTO. 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 1935 E. NORTH AVENUE 21213				
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE GREENE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET DAMEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	16b SOCIAL SECURITY NO. 220-03-1102	17 INFORMANT ADDRESS HELEN GREENE 1935 E. NORTH AVE.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1BP, CVD COA Pulmonary E. DUE TO, OR AS A CONSEQUENCE OF (c) CLB D. MALL, EUS.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7.29.87 P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 7.29.87 , 19 87 , to 7.17.87 , 19 87 that (I) (we) last saw the deceased alive on 7.19.87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE T. A. Brown	DEGREE MD		22c DATE SIGNED 8.5.87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) T. A. Brown	22e ADDRESS 2225 Elton Rd. Towson, 21221			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 8/8/87	23c NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD	
24 FUNERAL DIRECTOR NAME WM.C. MARCH F/H, INC.		25a DATE REC'D. BY REGISTRAR AUG 7 1987		25b REGISTRAR'S SIGNATURE Julia Sanders-Randall
ADDRESS 1101 E. NORTH AVE.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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REBEL MOTION PICTURE

REBEL MOTION PICTURE

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AUG 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

22746
8-15-87 10:25PM

1. DECEASED NAME (TYPE OR PRINT) NAN		FIRST MIDDLE LAST Greenfield		2a. DATE OF DEATH MONTH DAY YEAR 8-15-87		2b. TIME OF DEATH 10:25PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 12 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 86 YRS	
7a. BIRTHPLACE Baltimore Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levinson		12a. HOUSEHOLD (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST AARON NEUMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA BERGER		16. STREET ADDRESS / ZIP CODE 6009 Berkeley Ave. 21209			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-40-8731		17. INFORMANT MR. DAVID GREENFELD 6009 BERKELEY AVE. BALTO., MD 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Non Hodgkins lymphoma with metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 8/15/87 to 8/15/87, that (1) we last saw the deceased alive on 8/15/87, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)							
22b. SIGNATURE S. Levenson		22c. ADDRESS LEVINDALE - BALTO., MD 21215		22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. LEVENSON, M.D.		22e. DATE SIGNED 8/16/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY LUBAWITZ NUSACH ARI		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25. DATE REC'D. BY REGISTRAR AUG 20 1987			

MEDICAL CERTIFICATION

229

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

E0318547
2 27 47

FOR 1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST HAZEL	MIDDLE L.	LAST GRIFFIN	2a. DATE OF DEATH MONTH DAY YEAR August 23, 1987	2b. HOUR 5:41 P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6225 York Rd., 21212
14. FATHER'S NAME FIRST MIDDLE LAST Michael Noel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Lloyd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 05 2414		17. INFORMANT ADDRESS Robert L. Griffin, Pasadena, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> , 19 <u>83</u> , to <u>8-23</u> , 19 <u>87</u> , that (I) (last) saw the deceased alive on <u>8-21</u> , 19 <u>87</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.								
22b. SIGNATURE <u>Carla-wyff Rosenthal</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>8/24/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Carla Rosenthal, MD				22e. ADDRESS 3400 Brehms Lane, Balto., MD 21213				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/1/87		23c. NAME OF CEMETERY OR CREMATORY Jessop Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sparks, MD		
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co. 21212				25a. DATE REC'D. BY REGISTRAR SEP 1 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Danden-Rudner</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR		22748		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST James		MIDDLE H.		LAST Griffin		2. DATE OF DEATH MONTH DAY YEAR		2b HOUR	
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 7 30		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO		7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY		12b KIND OF BUSINESS OR INDUSTRY ST. OF MARYLAND	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MO		13b COUNTY Balt.		13c CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1601 CHILTON STREET 21218			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS GRIFFIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE ROBINSON							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 220-24-0028		17 INFORMANT ADDRESS HARRIET GRAY 1601 CHILTON STREET 21218							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) D.T.C. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) severe Liver Failure DUE TO, OR AS A CONSEQUENCE OF (c) severe CHF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure M.I.											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/24, 19 87, to 8/27, 19 87, that (I) (we) lost saw the deceased alive on 8/24, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Stephen J. Gordin				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/26			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Gordin				22e ADDRESS c/o Sinai Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 8/27/87		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d LOCATION CITY OR TOWN ANNE ARUNDEL CO.		STATE MD			
24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. North Ave. 21202				25 BY REGISTRAR AUG 27 1987				25b REGISTRAR'S SIGNATURE			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22749

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Noah James Grigo			2a. DATE OF DEATH MONTH DAY YEAR 8-14-87		2b. HOUR 1330 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR August 13, 1987		6. AGE (IN YEARS LAST BIRTHDAY) - YRS.	IF UNDER 1 YEAR MONTHS DAYS 1
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD.		13b. COUNTY HOWARD	13c. CITY OR TOWN ELLICOTT CITY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 8330 ELKO DR. 21043
14. FATHER'S NAME FIRST MIDDLE LAST KENNETH LEE GRIGO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRENDA ANN VOELKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT KENNETH L. GRIGO		ADDRESS 8330 ELKO DR. ELLICOTT CITY MD 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>August 13</u> , 19 <u>87</u> , to <u>August 14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <i>L. L. Sparks</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED August 14, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. L. Sparks		22e. ADDRESS St Agnes Hospital, 700 Canton Avenue, Baltimore, Maryland 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 16 AUGUST 87	23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALTO. MD.		
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 268 ELLICOTT CITY MD 21043	25a. DATE REC'D. BY REGISTRAR SEP 03 1987		
		25b. REGISTRAR'S SIGNATURE <i>L. L. Sparks</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or interment.

084737 SEP-68

SEP 03 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be conducted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				22750 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>GEORGE</u> <u>Leslie</u> <u>GROB</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>8</u> <u>11</u> <u>87</u>	
3. SEX <u>MALE</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>1</u> <u>22</u> <u>18</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.		7. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hospital</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Foreman/Factory</u>		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE <u>5238 PATRICK Henry Dr</u> <u>21225</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>HARRY</u> <u>GROB</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>EDNA</u> <u>GROB</u>		16. SOCIAL SECURITY NO. <u>213109314</u>	
17. INFORMANT ADDRESS <u>Leslie C. Grob 5301 Fourth St., Balto. Md. 21225</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinomatosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>28 min</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION <u>8/11/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>OBSTRUCTING Large Bowel</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>8-11</u> <u>1987</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the hospital attended the deceased from <u>8-8</u> <u>1987</u> to <u>8-11</u> <u>1987</u> , that (2) the deceased died on <u>8-11</u> <u>1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true, (c) did not view the body after death.)					
22b. SIGNATURE <u>Daniel Wenberg</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8-11-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANIEL WENBERG</u>		22e. ADDRESS <u>3001 South Hanover St</u>		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8/14/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, A.A. Co., Md.</u>		24. FUNERAL DIRECTOR NAME <u>McGully Funeral Homes</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 13 1987</u>	
25b. REGISTRAR'S SIGNATURE <u>John Swider-Rendall</u>					

BP

REGISTERED MAIL

064140 AUG 31 1987

Items 11 & 13 per phone

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 27 51

1. DECEASED NAME (TYPE OR PRINT)		FIRST Martin		MIDDLE		LAST Groh		2a. DATE OF DEATH MONTH DAY YEAR		8 22 87		2b. HOUR 5:45 PM	
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6/ 24 / 14		6. AGE (IN YEARS LAST BIRTHDAY)		73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Baltimore City		MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		Baltimore		Liberty Medical Center		un un	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		UNKN.		00000	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		LIBERTY MEDICAL CENTER - 578-2397	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Post obstructive Pneumonia, COPD</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 5, 19 87</u> to <u>August 22, 19 87</u> , that (I) (we) last saw the deceased alive on <u>August 22, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Eleanor Y. Hixon, MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/22/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eleanor Y. Hixon, MD		22e. ADDRESS 924 W. North Ave. Balt. MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		23g. REGISTRAR'S SIGNATURE	
Removal		8-25-87		UN		UN		AUG 27 1987		John Davidson-Randall		John Davidson-Randall	
24. FUNERAL DIRECTOR NAME ADDRESS		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE	
State Anatomy Board		Balto., Md.		AUG 27 1987		John Davidson-Randall		John Davidson-Randall		John Davidson-Randall		John Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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062775 AUG 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 2 2 7 5 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie Marguerite Gruber			2a. DATE OF DEATH MONTH DAY YEAR August 13, 1987		2b. HOUR 6:00 AM						
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCT. 20, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Highfield, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3900 North Charles Street				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) SALES		12b. KIND OF BUSINESS OR INDUSTRY Textile			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3900 N. CHARLES ST 21218			
14. FATHER'S NAME FIRST MIDDLE LAST Alvey Harbaugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula E. STEEM									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-3936		17. INFORMANT ADDRESS Louis Silberstein, Balto., MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY COLLAPSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GASTROINTESTINAL hemorrhage AND fluid loss 15 days DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA Colon - WIDESPREAD METASTASIS 6 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC CANCER to liver, lungs, bone, HYPERTENSION											
19a. DATE OF OPERATION JUNE 5, 1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colonic obstruction - tumor				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 600 N. Wolfe St. Baltimore, MD.		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-18 19 87 to 8-13 19 87 , that (I) (we) last saw the deceased alive on 8-13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William R. Bell, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/13/1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William R. Bell, MD		22e. ADDRESS 600 N. Wolfe St. Baltimore, MD. 21205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 8/17/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN Pikesville, MD		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co.		25. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

063454

AUG 21 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22753

REG. NO. 3

2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
8			15			87		
12			55			M		
3. SEX			4. RACE			5. DATE OF BIRTH		
MALE			WHITE			6 4 18		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
MD.			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore City			Denton Hosp. Med. Center South			Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		
Baltimore City			Denton Hosp. Med. Center South			Photographer Photo		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		
Phillip UNKNOWN			UNKNOWN BRIGITA SALA			16b. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
Phillip DUBICKI			215 S. Wolfe St.			PART 1. DEATH WAS CAUSED BY:		
1942			218-01-1041			IMMEDIATE CAUSE (a)		
1942			218-01-1041			Cardiopulmonary failure		
1942			218-01-1041			DUE TO, OR AS A CONSEQUENCE OF		
1942			218-01-1041			Metastatic Adenocarcinoma		
1942			218-01-1041			DUE TO, OR AS A CONSEQUENCE OF		
1942			218-01-1041			Approximate interval between onset and death		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/31 19 87, to 8/15 19 87, that (I) (we) lost saw the deceased alive on 8/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE B. Pimentel				DEGREE MD		22c. DATE SIGNED 8/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				22f. DATE RECORDED BY REGISTRAR			
B. Pimentel				South Balt. General Hospital				400 19 1987			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation				Aug 17 87		West View		Baltimore MD.			
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Shirley D. Lee				322 S. Angel St				Julia Gordon-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

003124 AUG 21 81

062138

AUG 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22754

REG. NO.

1. DECEASED NAME (Type or Print)		FIRST HENRY		MIDDLE Thurman		LAST GULLEY		2a. DATE OF DEATH		MONTH AUGUST	DAY 3, 1987	YEAR 1987	2b. HOUR 11:20p M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 22 1931		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHN'S HOPKINS HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Gen. Contractor			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #2 Bristol Avenue 21225					
14. FATHER'S NAME FIRST MIDDLE LAST Carl Gulley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		16c. SOCIAL SECURITY NO. 412-46-5582		17. INFORMANT Eleanor Gulley		ADDRESS Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Thrombotic stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myelogenous Leukemia</u>												3 weeks	
DUE TO, OR AS A CONSEQUENCE OF												4 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>87</u> , to <u>8/3</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (do) (did not) view the body after death.													
22b. SIGNATURE <u>Fred Williams, MD</u>								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/3/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Fred Williams</u>								22e. ADDRESS <u>600 N. WOLFE STREET, BALTO., MD</u> <u>The Johns Hopkins Hospital</u> 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/7/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans				23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md													

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

DO NOT
REPLY

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARSHALL		MIDDLE ABRAMS	LAST GUTIN	2a. DATE OF DEATH MONTH DAY YEAR		8 10 87		2b. HOUR 3:28 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JULY 25, 1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS 16 DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		7022 PLYMOUTH RD. #21208			
14. FATHER'S NAME FIRST MIDDLE LAST LAWRENCE GUTIN						15. MOTHER'S MAIDEN NAME MIDDLE REBECCA HARRIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS LAWRENCE GUTIN 7022 PLYMOUTH RD. BALTO., MD 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST SECONDARY TO HYPOXIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY INTERSTITIAL SYNDROME</u>										15 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>RESPIRATORY DISTRESS SYNDROME, PREMATURE</u>										16 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (this hospital) attended the deceased from <u>JULY 25</u> , 19 <u>87</u> , to <u>AUGUST 10</u> , 19 <u>87</u> , that (he) (we) last saw the deceased alive on <u>AUGUST 10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (he) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Peter M. Haney</u> MD PhD								22c. DATE SIGNED 8/10/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER M. HANEY MD PhD	
22e. ADDRESS <u>JOHN SINAI HOSPITAL OF BALTIMORE</u>								23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 11, 1987	
23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN								23d. LOCATION BALTIMORE		23e. COUNTY MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215								25. DATE REC'D. BY REGISTRAR AUG 14 1987			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Burial-transit permits remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for recording and filing.

IMPORTANT: If item 21 is marked or item 18 shows any significant other traumatic event, the medical examiner must be notified.

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